DISSERTATION ON
A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TEACHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN AT CHENNAI.

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CERTIFICATE

This is to certify that this dissertation titled **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TEACHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN AT CHENNAI"** is a bonafide work done by **Ms.P.SESHAMALINI,** M.Sc Nursing II year student, College of Nursing, Madras Medical College, Chennai - 03 submitted to The Tamilnadu Dr.M.G.R Medical University, Chennai-32, in partial fulfillment of the requirements for the award of degree of Master Of Science In Nursing, Branch–III, Obstetrics and Gynaecological Nursing, under our guidance and supervision during the academic year 2016 – 2018.

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ABSTRACT

Newborn babies constitute the essence of life. Most mothers observe their babies carefully. Mother plays a key role in identifying minor disorders. As she observes her baby, she might often get worried by minor physical and physiological peculiarities of the baby.

TITLE: "A study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward at Institute of Obstetrics and Gynecology and Government Hospital for Women and Children, Chennai".

NEED FOR STUDY: The few newborn problems are minor which can be handled by mothers at home, the postnatal mothers are not aware of the minor disorders of newborn, they must be educated and they should have the knowledge regarding various aspects of minor disorders of newborn to decrease the neonatal mortality and morbidity rate from preventable cause.

OBJECTIVES: To assess the pretest knowledge of postnatal mothers regarding selected minor disorders of newborn assess the effectiveness of planned teaching programme and **t**o determine the association between pretest and posttest knowledge scores on selected minor disorders of newborn with their selected demographic variables.

METHODS AND MATERIALS: This study was conducted with 60 samples (Postnatal mothers) in quantitative approach, Pre experimental one group pretest posttest design, sample selection was done by convenient sampling technique. Pre-existing knowledge was assessed by using semi Structured questionnaires. After the pre-test, Planned

teaching programme was given regarding selected minor disorders of newborn. After 5 days post-test was conducted by using same tool.

RESULTS: The findings of the study revealed that the PTP had improved the knowledge of postnatal mothers regarding selected minor disorders of newborn with paired t –test P value is 0.001. There is statistical significance in knowledge attainment on selected minor disorders of newborn among postnatal mothers.

CONCLUSION: The result of the study shows that PTP was effective in prevention and management of selected minor disorders of newborn among postnatal mothers.

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LIST OF ABBREVIATION

S. NO	ABBREVIATION	EXPANSION
1	AD	Acute Diarrhoea
2	CCD	Congenital Chloride Diarrhoea
3	CC	Chronic Constipation
4	DD	Diaper Dermatitis
5	DF	Degrees of Freedom
6	P	Significance
7	PTP	Planned Teaching Programme
8	SD	Standard Deviation
9	UNICEF	United Nation International Child Emergency Fund
10	WHO	World Health Organization

CHAPTER-I
INTRODUCTION

Behold, children are a heritage from the lord the fruit of the womb is a reward.

– Psalm 127:3

Newborn period encompasses the first four weeks of extrauterine life. Neonate are from birth to under four weeks of age that is less than 28 days, is called neonate or newborn. First week of life less than 7 days or less than 168 hours is known as early neonatal period. Late neonatal period extends from 7^{th} to less than 28^{th} day. It is an important link in the chain of events from conception to adulthood. The physical and mental well-being of an individual depends on the correct management of events in the perinatal period. The morbidity and mortality rates in newborn are high. In India, almost 7 out of 100 babies do not see their first birthday and nearly 65 percent of these infant deaths occur in the neonatal period, namely, the first four weeks of life. The current neonatal mortality rate in India is 45 per 1000 live births.[1.]

Globally the neonatal mortality has declined to some extent (from 33 deaths per 1000 live births in 1990 to 21 in 2012) because of the successful public health intervention. However, this progress is not enough. Currently, the leading causes of neonatal deaths in the world are infection, (diarrhoea), prematurity. In India the neonatal mortality rate is 39 per thousand live births. The neonatal deaths caused by infection are 33%, asphyxia21% and prematurity15%, 75% of deaths occur within 7 days of birth in which 40% deaths occur in the first day of life. Neonatal deaths during the first week of life are due to inadequate and inappropriate care during pregnancy and childbirth or during the first critical hours after birth. After the first week, the major causes of neonatal deaths are infection, diarrhea, preterm births, poor feeding

practices. These are some of the contributing factors to neonatal mortality.[2]

Vomiting is the most common problem of the neonates as complaint by the mothers. Mother needs explanation about the regurgitation of feeds and vomiting. Regurgitation of milk is never ejected forcefully, it just flows out of the mouth soon after feeding and usually due to faulty feeding technique and swallowed air while sucking. As the air is expelled, the part of the feed comes out. Constipation is common in artificial feeding especially with cow's milk. Other causes may be inadequate feeds or insufficient fluid intake. Breastfed baby passes two to six times golden yellow, sticky, semi-loose stools due to high content of lactose. Mother should be explained about the breastfed stools. The intake of large quantities of glucose water or honey by the baby may cause diarrhea.[3]

Unhygienic feeding practices overfeeding, bottle feeding and serious underfeeding also can cause diarrhea in the neonates. The serious neonatal diarrhea may also occur in septicemia, necrotizing enterocolitis etc., Napkin Rash commonly found in artificially fed babies and also called ammonia dermatitis. It can occur in prolonged wet nappies or lack of cleanliness. Perianal skin may become red, indurated and excoriated. Perianal dermatitis often found following diarrhea or fungal infection or due to use of nylon or water tight plastic napkins. Jaundice is the visible manifestation of hyperbilirubinemia. The clinical jaundice in neonates appear on the face at a serum bilirubin level of 5mg/dl. The yellowish discoloration is first seen on the skin of face, nasolabial folds and tip of nose in the neonates. It is detected by blanching the skin with digital pressure in the natural light. Neonatal jaundice is also termed as icterus neonatorum or as neonatal hyperbilirubinemia. There is elevation of unconjugated bilirubin

concentration due to immature liver in the first week of life causes physiological jaundice.[3]

A major reason for the high mortality rate is lack of care at birth. In India most the mothers are not aware of minor disorders of newborns. It is the responsibility of the nurse to educate mothers regarding the management of minor disorders of newborns , which is an extended activity for promotion of maternal and child well being. [4]

Because these first days and weeks are so critical, the care given by the nurse and the teaching provided for the parents are important communication and teaching skills contribute to the newborn's future well-being by helping the parents develop an understanding of their newborn's needs and acquire skill in his or her care. In this way, their concept of themselves as adequate parents is reinforced. The nurse also must be aware that some parents need assistance in developing healthy attitudes regarding child-rearing practices so that the newborn can make a satisfactory emotional and social adjustment. [2].

Most mothers observe their babies carefully and are often worried by minor physical peculiarities, which may be of no consequence. [5]

1.1 NEED FOR THE STUDY

The few newborn problems are minor which can be handled by mothers at home. But sometimes due to lack of knowledge these minor problems lead to fatal conditions, thus increasing the morbidity and mortality rate.

The minor disorders are most common among newborns, neglecting the minor health problem is the one of the factor contributing to the newborn mortality rate. In India most the mothers are not aware of management regarding minor disorders of newborn (vomiting, constipation, diarrhea, napkin rashes, and physiological

jaundice). In a view of limited studies and resources, important consideration on literature review taken.

The limited studies Mrs. MalarKodi Aathi, Devi SA, Kohli G (2013) they investigated the incidence of minor disorders of newborn including knowledge of postnatal mothers regarding minor disorders. Twenty research studies on nursing from databases regarding minor disorders of newborn. The incidence knowledge of postnatal mothers concludes most of the studies 10 (78%) shows mothers had below average knowledge and 66% mothers showed negative attitude and there was big gap between actual and desired practice in caring newborn. [4]

UNICEF 2018 states that the first 28 days of life- the neonatal period- are the most vulnerable time for a child's survival. Children face the highest risk of dying in their first month of life, at a global rate of 19 deaths per 1,000 live births. Globally, 2.6 million children died in the first month of life in 2016- approximately 7,000 newborn deaths every day most of which occurred in the first week, with about 1 million dying on the first day and close to 1 million dying within the next six days. [6]

WHO 2018 states that the first 28 days of life – the neonatal period represent the most vulnerable time for a child's survival. In 2016, 2.6 million deaths, or roughly 46% occur during this period. This translates to 7000 newborn deaths every day. The majority of the neonatal deaths are concentrated in the first day and week, with about one million dying on the first day and close to one million dying within the next six days. On current trends, more than 60 countries will miss the (Sustainable Development Goals) SDG target of reducing neonatal mortality to at least as low as 12 deaths per 1000 live births by 2030. About half of them will not reach the target by 2050. These countries carry about 80 percent of the burden of neonatal deaths in 2016. [7]

Neonates or new-born are the most delicate group among kids as they are not able to express their feelings happiness, sad, pain or discomfort and their systems are immature, just starting to adjust to the extra uterine life. Mother plays an important role in identifying minor developmental deviations and early evidence of the disease process because she is constantly and closely watching her baby. The most common minor problems occur in new-borns are vomiting, constipation, diarrhea, breath holding spells, cradle crap, physiological jaundice ,hiccups, napkin rash, abdominal colic, oral thrush, erythema toxicum (new-born rash), milia, Epstein pearl ,neonatal acne, neonatal conjunctivitis etc. Neonatal infections and the minor problems is one of the major leading causes of death during the neonatal period. It can contribute up to 13-15% of all deaths during the neonatal period with the mortality rate reaching as high as 50% for infants who are not treated timely. Postnatal mothers should be aware of common minor neonatal problems. [8]

Hence the postnatal mothers are not aware of the minor disorders of newborn, they must be educated and they should have the knowledge regarding various aspects of minor disorders of newborn to decrease the neonatal mortality and morbidity rate from preventable cause. So the investigator interested to do the research in this topic.

1.2 STATEMENT OF THE PROBLEM

"A study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among post natal mothers admitted in post natal ward at Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children at Chennai"

1.3 OBJECTIVES

1) To assess the pretest knowledge of postnatal mothers regarding selected minor disorders of newborn.

2) To assess the effectiveness of planned teaching programme on selected minor disorders of newborn among postnatal mothers.

3) To determine the association between pretest and posttest knowledge scores on selected minor disorders of newborn with their selected demographic variables.

1.4 OPERATIONAL DEFINITION

Assess: In this study it is an organized, systematic and continuous process of collecting and analyzing the data on knowledge regarding minor disorders of newborn among postnatal mothers.

Effectiveness of Planned Teaching Programme: In this study it refers systematically organized teaching strategy of planned material on knowledge regarding minor disorder of newborn among postnatal mothers with the help of flash card, pamphlets, duration is 45 minutes, and plan to give small group of 3 - 5 members per day.

Knowledge: Refers to the responses from the postnatal mothers regarding minor disorder of newborn through structured knowledge questionnaire.

Postnatal mother: It is a segregated place in the hospital where the mother stays from the time following delivery to next one week.

Newborn : The newborn period is defined as beginning at birth and lasting through the 28 th day following birth , from birth to under 4 weeks of age (< 28 days).

Minor disorders: Common health problems present newborns which can be managed before it's develops complications like vomiting, constipation, diarrhea, excessive crying, excessive sleepiness, dehydration fever, cradle cap, hiccups, sneezing and nose block, napkin rash, mastitis neonatorum, umbilical granuloma, vaginal bleeding and mucoid secretions, physiological phimosis, caput succedaneum, cephalhematoma, physiological jaundice, superficial infections.

In this study I have taken certain selected minor disorders of newborn such as vomiting, constipation, diarrhea, napkin rashes, physiological jaundice.

1.5 ASSUMPTION

- Mothers may have varying level of knowledge on minor disorders of newborn.
- Planned Teaching Programme may increase the knowledge about minor disorders of newborn.

1.6 HYPOTHESIS

H_1: There will be significant difference between the pre and posttest knowledge of postnatal mothers regarding minor disorders of newborn

H_2: There will be significant association between the posttest knowledge score of minor disorders of newborn with the demographic variables of postnatal mothers

1.7 DELIMITATION

- Data collection is four weeks.
- This study is limited to postnatal mothers and selected minor disorders of newborn includes (vomiting, constipation, Diarrhoea, napkin rashes, physiological jaundice).

CHAPTER-II
REVIEW OF LITERATURE

Review of literature is an essential component of research study as it provides a broad understanding of the research problem. It is a critical analysis of a segment of a published body of knowledge through summary, classification and comparison of prior research studies, review of literature and theoretical articles, keeping this in mind the investigator will make a thorough study on available source, which has been helpful in projecting the widened perspective of the study.

LITERATURE REVIEW RELATED TO THE STUDY

2.1.1 Literature related to mothers knowledge and management regarding selected common minor disorders of newborn.

2.1.2 Literature related to minor disorders of newborn (Vomiting, Diarrhoea, Constipation, napkin rash, physiological jaundice)

2.1.1 Literature related to mothers knowledge and management regarding selected common minor disorders of newborn.

Malarkodi, Akoijam Sangita, Gaurav Kohli, (2018) had conducted a study on minor disorders of newborn including knowledge of postnatal mother regarding minor disorders. Non Experimental approach, descriptive design was used and the study conducted in cambridge maternity centre, Bangalore. 50 postnatal mothers were chosen by using non probability convenient sampling technique. The data was collected through structured interview schedule. Among of 50 subjects 34(68%) had moderately adequate knowledge, 10(20%) had inadequate knowledge and remaining 6(12%) had adequate knowledge, chi-square was used in order to identify the association between the socio demographic variables and level of knowledge, It shows, there was no significant association between all socio demographic variables

except education of mothers, parity and previous information received by the postnatal mothers regarding minor disorders of newborn. [4]

Venu.A.S, Naveen Kumar P.R, Prashanth, et al., (2016), had conducted a study to assess the effectiveness of planned teaching programme on knowledge regarding common minor neonatal problems and its management among postnatal mothers. 30 postnatal mothers admitted in S.S Hospital were selected for the study by purposive sampling technique. The result revealed that the majority of postnatal mothers had average pretest scores that is 29(99%) and 1(1%) of postnatal mothers had poor knowledge regarding common minor neonatal problems. The mean knowledge scores in pre-test was 1.32 and SD was 0.469 and in post-test mean was 1.52 and SD was 0.499. So, it is evident that mean post-test knowledge score of postnatal mothers was significantly greater than their mean pre-test knowledge score. This shows that PTP (Planned Teaching Programme) on common minor neonatal problem and its management has enhanced knowledge on common minor neonatal problems. [10]

SaranyaS, Nandini M, Indra V,(2015), Conducted a study on Knowledge and attitude of mothers regarding management of selected minor ailments in neonates at selected hospital, Thrissur. It was based on modified Rosenstoch's Becker and Maiman's health Belief Model(HBM), Non experimental descriptive design is used conducted among 60 mothers of full term neonates The findings revealed that 50 (83.3%) mothers possessed inadequate level of knowledge, 10 (16.7%) had moderate level of knowledge and no one had adequate level of knowledge, Attitude, findings depicted that 14(23.3%) mothers had most favourable attitude, 46(76.7%) had favourable attitude and no one had unfavorable attitude. [11]

Mrs.Nagari Venkatalakshmi, (2014) had conducted a study regarding knowledge of postnatal mothers regarding minor disorders of new born, and non-experimental approach descriptive design was used and the study conducted in punarva maternity, postnatal mothers were selected by non-probability convenient sampling technique. Analysis & interpretation was done based on objectives of the study. Among of 50 subjects 34(68%) had moderately adequate knowledge 10(20%) had inadequate knowledge and remaining 6(12%) adequate knowledge. [12]

K.C. Leena, Deepthi A. Koshy, Denna Thankachen, Deepa Thomas, et al.,(2014), conducted a study regarding knowledge of common problems of newborn among primi mothers admitted in a selected hospital for safe confinement, This descriptive study was carried out among mothers of neonates in the maternity unit of a medical college hospital in Mangalore. The majority, 43 (71.67%), were in the age group of 21-25 years, 10 (16.6%) were in the 26-30-year-old group, and seven (11.67%) were in the age group of 16-20 years. The highest, 20 (33.3%) primi mothers, had completed high school, 19 (31.67%) secondary education, and nine (15%) primary level education. The majority, 36 (60%), were Muslims, 20 (33.33%) Hindus, and four (6.67%) Christians. The highest, 35 (58.33%), were from a joint family, 16 (31.6%) from a nuclear family, and six (10%) from an extended family. The majority, 36 (56.67%) of the primi mothers, were from rural areas. The majority, 46 (76.67%) primi mothers, were unemployed. Therefore, the null hypothesis is accepted and research hypothesis is rejected. [13]

2.1.2 Literature related to minor disorders of newborn (Vomiting, Diarrhoea, Constipation, Napkin rash, Physiological jaundice)

Vomiting

Burge DM, (2016), conducted a study regarding the management of bilious vomiting in the neonate. Bilious vomiting is synonymous with intestinal obstruction, be it functional or anatomical. In the neonate it may be due to congenital malformations of the gastrointestinal tract or develop due to acquired conditions, particularly intestinal complications associated with prematurity. This review considers the congenital malformations that may present with bilious vomiting and explores the diagnostic dilemmas faced in the preterm infant. The difficult issue of the need to exclude mal rotation in term infants with bilious vomiting and the consequences of time-critical transfer is discussed. [14]

Cizmeci MN, Kanburoglu MK, Akelma AZ, et, al.,(2014), conducted a descriptive study of transient neonatal feeding intolerance (TNFI) in a tertiary care center in Turkey. Participants are Term (≥ 37-weeks gestation) infants admitted to the neonatal intensive care unit with recurrent vomiting and refusal to feed. These infants were prospectively followed-up at 1, 2, 4, 6 months of age in the outpatient clinic. During the study period 1280 infants were evaluated in the maternity ward. Forty-eight (3.75%) neonates with repeated vomiting and refusal to feed were hospitalized from the maternity unit to the NICU Level I on the first postnatal day for further investigation. All infants started vomiting in the first day (median 5.75 hours; interquartile range: 1-24) and recovered by the 48th postnatal hour (median 27.5 hours; interquartile range: 14-48 hours). Laboratory and imaging studies showed no abnormalities. After discharge, 6-month follow-up of these infants showed no vomiting or feeding intolerance during well-child visits. They believe that expectant management and

supportive measures under skilled nursing care will prevent unnecessary diagnostic evaluation, mother/infant separation, and prolonged hospital stay. [15]

Ratnayake K, Kim TY, (2014), had conducted a study regarding evidence-based management of neonatal vomiting in the emergency department. And they account vomiting for up to 36% of neonatal visits to the emergency department. The causes of vomiting can range from benign to life-threatening. Evidence to guide the diagnosis and management of neonatal vomiting in the emergency department is limited. History and physical examination are extremely important in these cases, especially in identifying red flags such as bilious or projectile emesis. A thorough review is presented, discussing various imaging modalities, including plain abdominal radiography, upper gastrointestinal studies, ultrasonography, and contrast enema. A systematic approach in the emergency department, as outlined in this review, is required to identify the serious causes of vomiting in the neonate. [16]

Chan SM, ChanEK, Chu WC et, al., (2011), had conducted a study regarding Hypertrophic pyloric stenosis in a newborn. Hypertrophic pyloric stenosis typically present at 2 to 4 weeks of age with non bilious projectile vomiting. Also, the diagnostic criteria for ultrasonographic measurements in newborn infants have yet to be determined. This report is of a newborn infant with hypertrophic pyloric stenosis. The patient presented with high-volume non-bile-stained output from a nasogastric tube and a dilated gastric bubble on abdominal radiograph. Contrast study ruled out intestinal mal rotation. Two ultrasound tests showed that the pyloric muscle thickness and pyloric canal length were within normal limits. Subsequent laparotomy showed a thickened pylorus and pyloromyotomy was performed. The patient showed marked improvement in feeding postoperatively. A high index

of suspicion is required for newborn infants presenting with gastric outlet obstruction. Ultrasound and contrast studies provide additional information, but definitive diagnosis may only be available intra-operatively. [17]

Kimura K, Loening-Baucke V, (2000), had conducted a study regarding bilious vomiting in the newborn rapid diagnosis of intestinal obstruction, bilious vomiting in newborns is an urgent condition that requires the immediate involvement of a team of pediatric surgeons and neonatologists for perioperative management. However, initial detection, evaluation and treatment are often performed by nurses, family physicians and general pediatricians. Bilious vomiting, with or without abdominal distention, is an initial sign of intestinal obstruction in newborns. A naso- or orogastric tube should be placed immediately to decompress the stomach. Physical examination should be followed by plain abdominal films. Dilated bowel loops and air-fluid levels suggest surgical obstruction. Contrast radiography may be required. Duodenal atresia, midgut malrotation and volvulus, jejunoileal atresia, meconium ileus and necrotizing enterocolitis are the most common causes of neonatal intestinal obstruction. [18]

Constipation

Yanitskaya MY, Sapozhnikov VG,(2015) had explored a study on diagnostic possibilities of hydrocolonic echography at chronic constipation in children. On the basis of 15 years' of experience the criteria of assessment of the colon was developed when performing hydrocolonic echography (HCE) and the possibilities of HCE are evaluated at chronic constipations (CC) in children. A retrospective cross research of results of HCE in 263 children with CC aged from 14 days to 17 years was conducted. HCE allowed to evaluate the position of the colon in the abdominal cavity, gave information on lengthening and lumen of the colon, structure of the intestinal wall, haustra, peculiarities

of the functioning of the colon in real time. Secondary changes of the colon due to CC, depending on intensity of CC are identified. Echographical characteristics of dolihocolon (light constipations) and dolihomegacolon (severe constipations) are given. Possibilities of echographical identification of the surgical provenance (diseases of Hirschsprung,) of constipation in children are defined. Hydrocolonic echography grants high possibilities of diagnostics and allows identifying the organic reason of constipation in due time. [19]

Indrio F, Di Mauro, Riezzo G et, al.,(2014), had conducted a study regarding prophylactic use of a probiotic in the prevention of colic, regurgitation, and functional constipation: a randomized clinical trial, A prospective, multicenter, double-masked, placebo-controlled randomized clinical trial was performed on term newborns (age <1 week) born at 9 different neonatal units in Italy between September 1, 2010, and October 30, 2012. In total, 589 infants were randomly allocated to receive L reuteri DSM 17938 or placebo daily for 90 days. Parents were asked to record in a structured diary the number of episodes of regurgitation, duration of inconsolable crying (minutes per day), number of evacuations per day, number of visits to pediatricians, feeding changes, hospitalizations, visits to a pediatric emergency department for a perceived health emergency, pharmacologic interventions, and loss of parental working days. Main outcome was to reduction of constipation during the first 3 months of life. Cost-benefit analysis of the probiotic supplementation. the mean duration of crying time (38 vs 71 minutes; $P < .01$), the mean number of regurgitations per day (2.9 vs 4.6; $P < .01$), and the mean number of evacuations per day (4.2 vs 3.6; $P < .01$) for the L reuteri DSM 17938 and placebo groups, respectively, were significantly different. [20]

Wester T, (2013), explored a study such as functional constipation in children. The pediatric surgeon's perspective is the prevalence of functional constipation in children is almost 10%. The etiology is multifactorial and not fully understood. In the majority of cases, there is no organic explanation for the symptoms. However, it is very important to exclude organic causes, particularly in neonates and infants. There are warning symptoms, such as delayed passage of meconium, bilious vomiting and abdominal distention that should prompt further investigations. Fecal incontinence is a very common symptom secondary to fecal impaction. The first-line treatment for both disimpaction and maintenance is use of laxatives. Parental education is extremely important. There are very limited data on surgical approaches for functional constipation. [21]

Candy D, Paul S.,(2011) suggested a study on childhood constipation is generally idiopathic and has a prevalence of five to 30 per cent. It can have significant implications on the quality of life for both the child and their family. Families may delay presentation as they may feel embarrassed or fear receiving a negative response from the healthcare professionals. Parents may report different symptoms as "constipation" depending on their own beliefs and previous experiences. A detailed history taken with the parents, along with a review of the Bristol Stool Form Scale chart will help in establishing a clinical diagnosis of constipation in the child. Dietary intervention alone is not sufficient in treating constipation. Laxative therapy alongside dietary and lifestyle modifications will help manage constipation in the community. [22]

Nunez-Ramon R, Fabbro MA, Gonzalez-VelascoM,et, al., (2011), had conducted a study on determination of the anal position in newborns and in children with chronic constipation. A prospective random study was carried out in two European hospitals determining the

API in 1,012 neonates (529 in Group A, and 483 in Group B) and in 64 children suffering chronic constipation of ages between 3 months and 12 years (Group C). The incidence of AEA was 47% in females and 35% in males. In the neonates (Groups A and B), the position of the anus in the perineum was more anterior in females than in males ($p < 0.0001$); 31% of the newborns females with AEA presented with constipation in their first months of life. In the Group C patients, there was a high incidence of AEA, especially in the females, and we consider it to be the probable cause of this defecation disorder. [23]

Kocaay P, Egritas O, Dalgic B, (2011), had explored a study on Normal defecation pattern, frequency of constipation and factors related to constipation in Turkish children 0-6 years old. This descriptive study had been carried out in Gazi University School of Medicine Pediatric polyclinics between February-June 2007 and 1018 children aged 0-6 years were included. The study comprises data about defecation pattern and prevalence of constipation. Children were divided into five groups according to the age. Their parents were asked to complete a structured questionnaire. Forty-eight of 1018 children (4.7%) were diagnosed as constipated. Twenty-eight (58.3%) were male and 20 (41.7%) were female. Parents of the constipated children defined the major complaints with defecation as discomfort (33%), pain (25%), seldom defecation (21%), hard stools (17%) and rectal bleeding (4%). Eighteen parents (37.5%) thought that constipation is related to dietary type. Refraining from school toilet was defined by seven parents (14.6%). Constipation may predict serious organic problems in newborns; however organic problems are not encountered in 95% of bigger children. [24]

Diarrhoea

Radlovic N, Lekovic Z, Vuletic B, et al., (2015) had conducted a study on acute Diarrhoea in children. Acute diarrhea (AD) is the most frequent gastroenterological disorder, and the main cause of dehydration in childhood. It is manifested by a sudden occurrence of three or more watery or loose stools per day lasting for seven to 10 days, 14 days at most. It mainly occurs in children until five years of age and particularly in neonates in the second half-year and children until the age of three years. Its primary causes are gastrointestinal infections, viral and bacterial, and more rarely alimentary intoxications and other factors. As dehydration and negative nutritive balance are the main complications of AD, it is clear that the compensation of lost body fluids and adequate diet form the basis of the child's treatment. This primarily regards uncritical use of antibiotics and intestinal antiseptics in the therapy of bacterial diarrhea. The use of antiemetics, antidiarrhetics and spasmolytics is unnecessary and potentially risky, so that it is not recommended for children with AD. [25, 43.]

Shamaly H, Jamalia J, Omari H, et, al., (2013), explored a study on congenital chloride diarrhea CCD presenting in newborn as a rare cause of meconium ileus. Postpartum abdominal distention and meconium ileus may occur due to intestinal obstruction, Hirschprung disease or cystic fibrosis. They present a premature baby girl who had distended abdomen and lack of meconium immediately after birth. Surgical etiology was excluded and she was mistakenly suspected of having cystic fibrosis due to meconium ileus. CCD was diagnosed by recognition of watery diarrhea in association with hyponatremic, hypochloremic metabolic acidosis. Mutation analysis confirmed the diagnosis. [26]

Krzemien G, Szmigielska A, Jankowska K et al., (2013), has conducted a study on Congenital chloride diarrhea mimicking meconium ileus in newborn**.** Congenital chloride diarrhoea is a rare autosomal recessive disease and the diagnosis is frequently delayed. The disease is most common in Saudi Arabia and Kuwait 1:3200-13 000 births, Finland - 1:30 000-40 000, and in Poland - 1:200 000. The article is a report on a 3-months old boy with the history of dilated bowel loops in prenatal ultrasonograhy, low birth weight and abdominal distention. Because of the suspicion of mechanical bowel obstruction he had laparotomy on the second day of his life. Mechanical obstruction was excluded and enterostomy was performed. The electrolyte disturbances were corrected and enterostomy was closed after six weeks. The final diagnosis of congenital chloride diarrhea was established two months later, when the patient was admitted to hospital again with severe watery diarrhea, metabolic alkalosis, hypochloraemia and hypokalemia. The stool chloride concentration was >90 mmol/L. Water and electrolyte deficits had been corrected. [27]

Igrutinovic Z, Peco-Anti A, Radlovic N, et al., (2011), has concluded a study on pseudo-bartter syndrome in an infant with congenital chloride Diarrhoea**.** A male newborn born in the 37th gestational week (GW) to young healthy and non-consanguineous parents. In the 35th GW a polyhydramnios with bowel dilatation was verified by ultrasonography. The laboratory results showed hyponatraemia (123 mmol/L), hypokalaemia (3.1 mmol/L), severe hypochloraemia (43 mmol/L), alkalosis (blood pH 7.64, bicarbonate 50.6 mmol/L), high plasma renin (20.6 ng/ml) and aldosterone (232.9 ng/ml), but a low urinary chloride concentration (2.1 mmol/L). Based on these findings, as well as the stool chloride concentration of 110 mmol/L, the patient was diagnosed congenital chloride diarrhoea. In further course, the patient was treated by intensive fluid, sodium and

potassium supplementation which resulted in the normalization of serum electrolytes, renal function, as well as his mental and physical development during 10 months of follow-up. [29]

Passariello, Terrin G, Baldassarre ME, et al.,(2010) suggested a study on Diarrhea in neonatal intensive care unit, to investigate the frequency, etiology, and current management strategies for diarrhea in newborn. Retrospective, nationwide study involving 5801 subjects observed in neonatal intensive care units during 3 years were done. Thirty-nine cases of diarrhea (36 acute, 3 chronic) were identified. The occurrence rate of diarrhea was 6.72 per 1000 hospitalized newborn. Etiology was defined in 29 of 39 newborn (74.3%): food allergy (20.5%), gastrointestinal infections (17.9%), antibiotic-associated diarrhea (12.8%), congenital defects of ion transport (5.1%), withdrawal syndrome (5.1%), Hirschsprung's disease (2.5%), parenteral diarrhea (2.5%), cystic fibrosis (2.5%), and metabolic disorders (2.5%). Three patients died due to complications related to diarrhea (7.7%). In 19 of 39 patients (48.7%), rehydration was performed exclusively by the enteral route. Diarrhea in neonates is a challenging clinical condition due to the possible heterogeneous etiologies and severe outcomes. Specific guidelines are advocated in order to optimize management of diarrhea in this particular setting. [30]

Bishop RF, Cameron DJ, Barnes GL, et al., (1976) conducted a study on etiology of diarrhoea in newborn infants. Diarrhoea is a common problem in newborn infants in hospital nurseries. In the past, sporadic diarrhoea was often attributed to dietary indiscretion by the mother, and epidemic diarrhoea was thought to be caused by an unknown infectious agent. Techniques with which to locate non-cultivable viruses and un typable enter pathogenic strains of Escherichia coli allow reevaluation of the etiology of diarrhoea in newborn infants. Preliminary results from Melbourne, Australia, suggest that

most diarrhoea in newborn infants is induced by a specific infectious agent. During 1975 the agent most often identified from sporadic and epidemic diarrhoea in hospital nurseries was a reovirus-like particle ("duovirus"). Enterotoxin-producing strains of E. coli were rarely isolated. Future attempts to protect newborn infants from developing diarrhoea must be based on an accurate understanding of the etiology of this disease. [31]

Napkin Rashes

Kayaoglu S, Kivanc- Altunay I, Sarikaya S,(2015), suggested a study regarding diaper dermatitis in infants admitted to social pediatrics health center, the objective was to determine infant diaper dermatitis (DD) at pediatrics health center. The methods included 113 infants aged 0-24 mo. Infants with minimum one time rash, were accepted to have DD. Seventy six (67.3 %) infants had DD [32 girls (42.1 %), 44 boys (57 %), mean age: 6.5 mo]. Infants with DD had significantly higher age than those without (p 0.001). DD frequency in infants ≥4.5 mo-old was 5.8(2.4-13.7) times more than in infants ≤4.5 mo. Cleaning material types did not affect DD frequency. No significant difference was observed in DD with diaper change of ≤3 times and ≥4 times. Rash incidence was significantly lower with cream use compared to without its use ($p < 0.001$). Mothers should be informed on dermatitis care and encouraged for breastfeeding. [32]

Tuzun Y, Wolf R, Baglam S, et al.,(2015), suggested a study on Diaper (napkin) dermatitis, is an acutely presenting inflammatory irritant contact dermatitis of the diaper region. In the past, the disease was thought to be caused by ammonia; however, a number of factors, such as friction, wetness, inappropriate skin care, microorganisms, antibiotics, and nutritional defects, are important. Families need to be informed about the importance of a clean, dry diaper area and the frequency of diaper changes. The use of superabsorbent disposable

diapers has decreased the incidence of the disease. Soap and alcohol-containing products should be avoided in cleaning the area. In some cases, corticosteroids and antifungal agents can be administered. If necessary, antibacterial agents and calcineurin inhibitors can also be beneficial. [33]

Lavender T, Furber C, Campbell M, et, al., (2012), explored an article on effect on skin hydration of using baby wipes to clean the napkin area of newborn babies A prospective, assessor-blinded, randomized controlled equivalence trial was conducted during 2010. Healthy, term babies (n=280), recruited within 48 hours of birth, were randomly assigned to have their napkin area cleansed with an alcohol-free baby wipe (140 babies) or cotton wool and water (140 babies). Primary outcome was change in hydration from within 48 hours of birth to 4 weeks post-birth. Secondary outcomes comprised changes in trans-epidermal water loss, skin surface pH and erythema, presence of microbial skin contaminants/irritants at 4 weeks and napkin dermatitis reported by midwife at 4 weeks and mother during the 4 weeks. Complete hydration data were obtained for 254 (90.7 %) babies. No significant differences were found in the secondary outcomes, except for maternal-reported napkin dermatitis, which was higher in the water group (p=0.025 for complete responses). Baby wipes had an equivalent effect on skin hydration when compared with cotton wool and water. [34]

Davies MV, Dore AJ, Perissinotto KL, (2005), suggested a study on topical vitamin A, or its derivatives, for treating and preventing napkin dermatitis in infants. Randomized controlled trials, where the topical application of medication containing vitamin A (or its derivatives) was compared with either placebo, no treatment or other topical medication, for the prevention or treatment of napkin dermatitis in infants aged from zero to two years. This included study, of 114 newborn infants, reported no significant differences between groups

with regard to the severity or duration of napkin dermatitis. For the treatment of napkin dermatitis there is no evidence to support or refute the use of topical vitamin A preparations. For the prevention of napkin dermatitis there is no evidence to suggest that topical vitamin A alters the development of napkin dermatitis. Further RCTs are required to determine whether topical vitamin A is efficacious in treating or preventing napkin dermatitis. [35]

Physiological Jaundice

Seyyedrasooli A, Valizadeh L, Hosseini MB,et, al.,(2014), conducted a study on effect of vimala massage on physiological jaundice in infants. This is a single blind clinical trial study, 43 healthy term infants, with 1st day Bilirubin levels of less than 5mg/dl, carried out in Tabriz Al-Zahra hospital. Newborns were selected through convenience sampling and then randomly assigned to intervention and control groups. Control group received routine care, while newborns of intervention group received four days of Vimala massage starting from the first day of their birth. The findings show that vimala massage within four days has no effect on increasing process of bilirubin, yet can affect the incidence rate of physiological Jaundice and care of infants by increasing defecation frequency. [36]

Chen J, Sadakata M, Ishida M, et al., (2011) explored a study on Baby massage ameliorates neonatal jaundice in full-term newborn infants. In the present study, the effects of gentle baby massage on neonatal jaundice in full term newborn infants were evaluated by a controlled clinical trial. Breastfed newborns without phototherapy were included, 20 in the massage group and 22 in the control group. They found the mean stool frequency of the massaged infants on day 1 and day 2 (4.6 and 4.3) was significantly higher than that of the control group (3.3 and 2.6) ($p<0.05$). In conclusion, baby massage at an early

stage after birth could reduce neonatal bilirubin levels. They suggest baby massage is beneficial for ameliorating neonatal jaundice. [37]

Siklar Z, Ocal G, Bilir P, et al., (2009), has explored a study regarding Maternal/Neonatal" iodine status in patients with prolonged physiological jaundice. The aim of the study is to investigate the frequency of borderline or overt hypothyroidism in a group of newborn with prolonged physiological jaundice, and to evaluate iodine status of these babies and their mothers. Fifty-five apparently healthy newborn were evaluated. Twenty-five of them showed borderline thyroid dysfunctions. Remained 30 babies had normal thyroid function, considered as euthyroid group. Iodine status was evaluated by measuring urinary iodine excretion. maternal iodine deficiency (55%) associated with neonatal iodine overload (65%) had came to attention. Although mean urinary iodine levels in both mother groups were similar, the mean urinary levels of borderline hypothyroidic and euthyroid groups were 432+/-129 microg/l and 271.5+/-137 microg/l, respectively. Iodine overload was also present in newborn with normal thyroid function tests. They considered that individual sensitivity to iodine overload could make the differentiation on thyroid function. [38]

Agarwal V, Singh V, Goel SP, et al., (2007), suggested a study on maternal and neonatal factors affecting physiological jaundice in western U.P. Several maternal and fetal factors are responsible for neonatal jaundice, which is a common observation in large number of newborns. However, role of these factors in causation of this condition is not well established. Fifty pregnant mothers and their fifty two newborns were studied in the present study. The serum concentrations of bilirubin of all neonates were measured on days 1, 3 and 5. It was found to be lower on day 1, with a peak at day 3. The area under serum bilirubin level-time curve (AUC) for each neonate was also calculated. Fetal sex and birth weight were not found to significantly

affect the neonatal hyperbilirubinemia. Newborn of bipara mothers were found to have significantly lower ($P < 0.05$) serum bilirubin level on day 1 as compared to mothers only but higher ($P < 0.05$) on day 3 as compared to either or multipara mothers. Yet, AUC of serum bilirubin curve was significantly higher ($P < 0.05$) in newborns of bipara mothers than others. Significantly ($P < 0.05$) higher serum bilirubin on day 1 was also observed in preterm neonates than full term ones. However, maternal hemoglobin and mode of delivery were not shown to affect the neonatal bilirubin levels in these newborns. [39]

2.2 CONCEPTUAL FRAMEWORK

Modified Ernestine Wiedenbach helping art theory (1964)

The conceptual frameworks are global ideas about the concept in relation to a specific discipline conceptual model are made up of concept which describe the mental images of a phenomena and integrate them into a meaningful configuration. It is a visual diagram by which the researcher explains the specific area of interest.

Wiedenbach conceptual model elaborately explained in means element that is identification of the patient's need for help, ministration of the needed and validation of that help. **Ernestine Wiedenbach** is a nurse theorist who qualified as a nurse midwife. Wiedenbach is considered to have developed her theory inductively from experience and observation of practice. This broad conceptual model encompasses five elements are interpreted in this study as follows.

THE AGENT

The agent who is the practicing nurse or her delegate. In this study, the agent is the investigator postnatal mothers and her neonates.

THE GOAL

The goal is the needed result which the nurse to achieve. In this study, the goals are prevention and management of selected minor disorders of newborn

MEAN

The means is the way in which the practitioner is enabled to attain her goal. In this study, mean is usage of flash card.

THE FRAME WORK

The framework consists of human, environmental, professional and organizational facilities that not only make up the context within

which nursing is practiced. In this study the framework is postnatal ward in Institute of Obstetrics and Gynaecology, Egmore.

Nursing practice has 3 components

IDENTIFICATION

The investigator included subjects has postnatal mothers of Institute of Obstetrics and Gynecology, Egmore. The postnatal mothers need for help are assessed in the identification phase. The postnatal mothers are in need of getting information regarding prevention and management of selected minor disorders of newborn. Hence, they have a lot of factors which is affecting that they are Age, educational status, religion, type of family, monthly income, occupation, place of residence, Mode of delivery.

MINISTRATION

It refers to the action needed to accomplish the desired task. In this study planned teaching programme is the intervention was given to postnatal mothers were assessed by using semi structured knowledge questionnaire.

VALIDATION

Validation phase has been done after the intervention. The effect of planned teaching programme was assessed in terms of gain in knowledge regarding prevention and management of selected minor disorders of newborn among postnatal mothers.

The investigator found that planned teaching programme was effective in terms of gain of knowledge regarding prevention and management of selected minor disorders of newborn among postnatal mothers.

CHAPTER-III
METHODOLOGY

This chapter deals with the research design, research approach, , study setting, sample, sample size and sampling technique, data collection method, development and description of tool, data collection procedure and plan for data analysis based on the research methodology adopted to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among post natal mothers admitted in postnatal ward Institute of Obstetrics and Gnaecology Government Hospital for Women and Children at Chennai.

3.1. RESEARCH APPROACH

Quantitative research approach

3.2. RESEARCH DESIGN

The pre- experimental research design was used one group pretest and posttest to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among post natal mothers.

3.1 Table Description of Study Design

O1	X	O2
Pretest assessment of level of knowledge	planned teaching programme	Posttest assessment of level of knowledge

KEY NOTES

O 1 - Pre- test assessment of level of knowledge regarding minor disorders of newborn.

X - Planned Teaching Programme on minor disorders of newborn.

O 2 - Post- test assessment of level of knowledge regarding minor disorders of newborn

3.3. STUDY SETTING

The study was conducted in postnatal ward at Institute of Obstetrics and Gynecology and government hospital for Women and Children, Egmore, Chennai-08. The Institute was unveiled on 26th July 1844 for public service. It is a 1075 bedded maternity hospital, tertiary care center and referral center. The hospital is renowned for its excellence in medical experts, nursing care and quality diagnostic services. All facilities are provided for conducting normal, high risk and instrumental deliveries. IOG has departments like neonatal intensive care unit, family planning services, oncology department, endocrinology, human milk bank and genetic department which are rendering comprehensive care for entire Tamilnadu and neighbouring states like Andhra Pradesh also.

3.4. DURATION OF THE STUDY

Four weeks.

3.5. STUDY POPULATION:

3.5.1. General population: Postnatal mothers

3.5.2. Target population: The target population consists of postnatal mothers admitted in postnatal wards at Institute of Obstetrics and Gynecology and Government Hospital for Women and Children, Egmore, Chennai.

3.5.3. Accessible population: Postnatal mothers in first week of postnatal period, who were admitting at Institute of Obstetrics and Gynecology and Government Hospital for Women and Children, Egmore, Chennai during the period of data collection.

3.6. SAMPLE

Sample consists of postnatal mothers who were admitted in postnatal ward and fulfil the Inclusion criteria.

3.7. SAMPLE SIZE

The sample comprise of 60 postnatal mothers of neonates who have admitted the postnatal wards at Institute of Obstetrics and Gyanecology and Government Hospital for Women and Children, Egmore, Chennai.

3.8. SAMPLING CRITERION

3.8.1. Inclusion criteria

Mothers Those

1) who are willing to participate in the study

2) who are primi para postnatal mothers to participate in the study

3) who are primi para postnatal mothers available at the time of data collection

4) who can understand Tamil and English language

3.8.2. Exclusion criteria: mothers those

1) who are not willing to participate in the study

2) who are having other complications like postnatal psychosis, postpartum hemorrhage and ICU cases.

3.9. SAMPLING TECHNIQUE

The sampling technique used for this study was non-probability convenient sampling technique.

3.10. RESEARCH VARIABLES

The variables mainly included in this study are independent and dependent variable. Dependent variable explains the effect of independent variable.

3.10.1. Dependent variable

Knowledge of postnatal mothers regarding selected minor disorders of newborn.

3.10.2. Independent variable

Planned teaching programme of selected minor disorders of newborn.

3.11. DEVELOPMENT AND DESCRIPTION OF THE TOOL

3.11.1. Development and description of data collection tool

Data collection tool was developed by the researcher on the basis of objectives of the study. After extensive review of literature, internet search and expert opinion helped the investigator to select the suitable tool to assess the level of knowledge among postnatal mothers.

Process of development of the tool

A structured knowledge questionnaire was developed by the investigator for assessing the knowledge of postnatal mothers regarding the prevention and management of selected minor disorders of newborn. For the development of the tool, research and non-research literature was reviewed and suggestions of experts and present statistics were taken to determine the areas to be included.

The following steps were undertaken to prepare the final tool:

- ❖ Development of the tool
- ❖ Content validity of the tool
- ❖ Pre-testing the tool
- ❖ Reliability of the tool
- ❖ Development of the final draft of the tool

The tool was developed with two parts:

Part-I: Socio Demographic Data -The socio demographic data was prepared with 9 items to collect the personal information of the subjects.

Part-II: **S**tructured Knowledge Questionnaire

The structured knowledge questionnaire was prepared with 25 questions divided into five sections.

Section A: Knowledge questionnaire regarding vomiting.

Section B: Knowledge questionnaire regarding constipation.

Section C: Knowledge questionnaire regarding diarrhea.

Section D: Knowledge questionnaire regarding napkin rashes.

Section E: Knowledge questionnaire regarding physiological jaundice.

Scoring Procedure

Each correct answer scored as 1 and remaining scored as 0

Scoring key for the knowledge

Level of knowledge	Score
Inadequate	<50%
Moderately	50-75%
Adequate	>76%

DEVELOPMENT OF THE INTERVENTION

The researcher developed the planned teaching program6mme in a lesson plan method regarding prevention and management of selected minor disorders of newborn with the consultation of various subject experts. The content in planned teaching programme which includes:

- General concept of minor disorders of newborn
- Causes, prevention and its management of vomiting
- Causes, prevention and its management of constipation
- Causes, prevention and its management of diarrhea.
- Causes, prevention and its management of napkin rashes
- Causes, prevention and its management of physiological jaundice

3.12. CONTENT VALIDITY OF THE TOOL

- The prepared data collection tool, along with the problem statement, objectives.
- Hypothesis, operational definitions and blue print designed for validation were submitted to experts.
- The experts were requested to give their opinion and suggestion regarding the relevance, adequacy and appropriateness of items in the tool.
- The modifications were made in the tool as per the validators suggestions.

3.13. PROTECTION OF HUMAN SUBJECTS

By submitting the study proposal, permission was obtained from the Institutional ethics committee thus, the investigator followed the ethical guidelines which were issued by the institutional ethics committee. Written consent was obtained from all participants. Throughout the period of the study the respect of all the mothers of neonates and the family members and ensure confidentiality was maintained.

3.14. RELIABILITY OF THE TOOL

After construction of questionnaire for the study on " A Study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among post natal mothers admitted in post natal ward Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children at Egmore in Chennai", it was tested for its validity and reliability. The reliability obtained was **0.86** which proved the effectiveness and efficiency of the tool.

Validity of the tool was assessed using content validity. Content validity was determined by Nursing and Medical experts. They suggested certain modifications in tool. After the modifications they agreed this tool for evaluate the effectiveness of planned teaching programme on knowledge of selected minor disorders of newborn among postnatal mothers in Institute of Obstetrics and Gynaecology and Government Hospitals for Women and Children, Egmore.at Chennai.

3.15. PILOT STUDY

The pilot study was conducted by selecting 6 postnatal mothers who were not participated in the main study for one week from 24.07.2017 to 30.07.17 after getting permission from the director at Institute of Obstetrics and Gynaecology and Government Hospitals for Women and Children Egmore at Chennai. Preceding the study, participant consent was obtained and all the information about samples was kept confidential.

3.16. DATA COLLECTION PROCEDURE

The formal written permission was taken from the hospital authorities for conducting study and with the co-operation of hospital staff and the feasibility of conducting study was assured. Data collection started from 02.01.2018 to 28.01.2018. The investigator established good rapport with the postnatal mothers at Institute of Obstetrics and

Gynecology and Government Hospital for Women and Children, Chennai. After an initial task of assembling the mother of newborn, the investigator introduced herself, explained the purpose of the study, ensured confidentiality.

The main study was conducted for 4 weeks. Every day an average of 3 to 5 subjects who were satisfying the inclusion criteria was selected and took a consent from each mother to participate in the study and collected socio-demographic data. Semi structure questionnaire was constructed and interview method was used to collect my data. Pretest was conducted regarding the prevention and management of selected minor disorders of newborn. The planned teaching programme was given soon after pre test was conducted by using flash card and pamphlet.

The subjects were eager to know and took active participation in asking question seeking clarification. Posttest was done on 5^{th} day of planned teaching programme. The investigator observed and scored the mother's knowledge regarding minor disorders of newborn by using structured questionnaire tool.

3.17. DATA ENTRY AND ANALYSIS

In order to achieve the stated objectives of the study, the data obtained from the subjects were coded numerically and tabulated. After tabulation and coding, enter the data into a spread sheet by the keyboard, the collected data was analyzed with the descriptive and inferential statistics like student independent't' test were used to test the hypothesis. Qualitative level of knowledge in pretest and posttest were compared using extended Mc Nemar test. The one way ANOVA F- test was used to find out the association between demographic variables with knowledge scores.

CHAPTER-IV
DATA ANALYSIS AND INTERPRETATION

This chapter deals with analysis and interpretation of data collection from 60 mothers "To evaluate the effectiveness of planned teaching programme (PTP) on knowledge of selected minor disorders of newborn among postnatal mothers in Institute of obstetrics and Gynecology, Egmore".

The study aimed to evaluate the effectiveness of PTP on knowledge of selected minor disorders of newborn among postnatal mothers. The data was collected from 60 samples. The findings were tabulated and interpreted in this chapter. The data were analyzed by using descriptive and inferential statistics. The data was analyzed based on the objectives formulated by the researcher.

ORGANIZATION OF THE DATA

The analyzed data were tabulated under the sections given below.

Section-A: Description of demographic profile of the postnatal mothers.

Section-B: Data on pre and post assessment knowledge of minor disorders of newborn among postnatal mothers.

Section-C: Data on comparison of pre assessment and post assessment knowledge of minor disorders of newborn among postnatal mothers.

Section-D: Effectiveness of planned teaching programme on selected minor disorders of newborn among postnatal mothers.

Section-E: Association between the level of pretest and posttest knowledge with the demographic variables of postnatal mothers.

STATISTICAL ANALYSIS

1) Demographic variables in categories were given in frequencies with their percentages.

2) Knowledge score were given in mean and standard deviation.

3) Association between demographic variables and knowledge score were analyzed using Pearson chi-square test

4) Quantitative knowledge score in pretest and posttest were compared using student's paired t-test.

5) Qualitative level of knowledge in pretest and posttest were compared using Stuart-Maxwell test /extended McNemar test

6) Association between knowledge gain score gain score with demographic variables are assessed using one way ANOVA F-test and student independent t –test.

7) Simple bar diagram, Multiple bar diagram, Pie diagram and Box plot were used to represent the data .8 .$P<0.05$ was considered statistically significant. All statistical test are two tailed test.

SECTION-A: DESCRIPTION OF DEMOGRAPHIC PROFILE OF THE POSTNATAL MOTHERS.

Table-4.1: Distribution of the Demographic variables of postnatal mother

Demographic variables		Postnatal mothers	Percentage
Educational status of the mother	No formal education	13	21.7%
	Primary school	18	30.0%
	Higher secondary school	16	26.6%
	Graduate	13	21.7%
Occupation	Houser wife	39	65.0%
	Self employee	10	16.7%
	Professional	6	10.0%
	Coolie	5	8.3%
Monthly income	< Rs.2101	18	30.0%
	Rs.2102 – Rs. 6297	24	40.0%
	Rs.6298 -- Rs.10495	11	18.3%
	> Rs.10496	7	11.7%
Religion	Hindu	47	78.3%
	Muslim	3	5.0%
	Christian	10	16.7%
Residence	Rural	15	25.0%
	Urban	39	65.0%
	Semi urban	6	10.0%

Demographic variables		Postnatal mothers	Percentage
Age of the child	0 -3 days	39	65.0%
	4 -6 days	19	31.7%
	6 -9 days	2	3.3%
	9 -12 days	0	0.0%
Age of the mother	18 -21 years	26	43.3%
	22 - 25years	24	40.0%
	25 – 29 years	8	13.4%
	> 29 years	2	3.3%
Mode of delivery	Normal vaginal delivery	38	63.3%
	LSCS	18	30.0%
	Forceps delivery	4	6.7%
	Outside delivery	0	0.0%
Weight of the baby	2 kg to 2.4 kg	5	8.3%
	2.5kg to 2.8 kg	23	38.4%
	2.9 kg to 3.4 kg	29	48.3%
	More than 3.5kg	3	5.0%

Table 4.1 shows the demographic information of postnatal mothers those who are participated for the following study **"**A study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward at Institute of obstetrics and gynaecology and government hospital for women and children at Egmore in Chennai."

Out of 60 postnatal mothers **educational status** of the mothers such as primary school was highest and no formal education are less.

In this study out of 60 postnatal mothers, 65% are **house wife**, 16.7% were self-employee, 10.0% were Professional, and 8.3% were Coolie.

The monthly **economic status** of the family shows that 40.0% were Rs.2102-Rs.6297, and 11.7% shows more than Rs. 10496.

With regarding of **religion**, the majority of the postnatal mothers belongs to Hindu religion of 78.3%, Muslim were 5.0%, and Christian were 16.7%.

With regard to **place of residence**, the majority of the mothers belongs to Urban area of 65% and Rural area of 25%.

With regard to **age,** the newborn age belongs to 65% were 0-3 days and 3.3% are 6-9 days. Postnatal mothers age belongs to 43.3% were 18-21 years, and more than 29 years of age are 3.3%.

Regarding **mode of delivery**, the majority of the postnatal mothers were normal vaginal delivery of 63.3% and Forceps delivery are 6.7%.

The majority of the newborn baby's weight belongs to (2.9 to 3.4) kg of 48.3% and least number belongs to (2 to 2.4) kg of 8.3%.

SECTION-B: DATA ON PRE AND POST ASSESSMENT KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS

Table-4.2: Each domain wise pretest percentage of knowledge on minor disorders of newborn among post natal mothers

S. No	Domains	No. of questions	Min – Max score	Knowledge score		
				Mean	SD	% of mean score
1	Vomiting	5	0 -5	2.25	.93	45.00%
2	Diarrhoea	5	0 - 5	2.28	.80	45.60%
3	Constipation	5	0 - 5	2.55	.93	51.00%
4	Napkin Rashes	5	0 - 5	2.10	.73	42.00%
5	Physiological jaundice	5	0 - 5	1.60	.87	32.00%
	Total	25	0 - 25	10.78	2.94	43.12%

Table 4.2 shows each domain wise pre-test percentage of knowledge of minor disorders of newborn among post natal mothers. They were having maximum knowledge in **Constipation** (51.00%) and minimum knowledge score in **Physiological jaundice** (32.00%).

Table-4.3: Overall Pretest Knowledge Score

	No. of questions	Min – Max score	knowledge score	
			Mean ±SD score	%
Overall score	25	0 -25	10.78±2.94	43.12%

Table 4.3 shows, pre-test percentage of knowledge of minor disorders of newborn among postnatal mothers Overall pretest percentage of knowledge score is 43.12% among postnatal mothers.

Table-4.4 : Pretest Level of Knowledge

Level of knowledge	No. of mothers	Percentage
Inadequate knowledge	46	76.7%
Moderate knowledge	14	23.3%
Adequate knowledge	0	0.0%
Total	60	100%

Table 4.4 shows the level of knowledge of minor disorders of newborn among postnatal mothers. In general 76.7% of mothers were having inadequate knowledge and 23.3% of them having moderate knowledge and none of them were having adequate knowledge.

Table-4.5: Each Domainwise Posttest Percentage of Knowledge on Minor Disorders of Newborn among Post Natal Mothers

S. No	Domains	No. of questions	Min – Max score	Knowledge score		
				Mean	SD	% of mean score
1	Vomiting	5	0 -5	4.28	1.06	85.60%
2	Diarrhoea	5	0 - 5	4.13	1.11	82.60%
3	Constipation	5	0 - 5	4.15	.90	83.00%
4	Napkin Rashes	5	0 - 5	4.07	.90	81.40%
5	Physiological jaundice	5	0 - 5	3.97	.78	79.40%
	Total	25	0 - 25	20.60	2.70	82.40%

Table 4.5 shows each domain wise post-test percentage of knowledge of minor disorders of newborn among postnatal mothers. They were having maximum knowledge in **vomiting** (85.60%) and minimum knowledge score in **Physiological jaundice** (79.40%).

Table-4.6: Overall Posttest Knowledge Score

	No. of questions	Min – Max score	knowledge score	
			Mean ±SD score	%
Overall score	25	0 -25	20.60±2.70	82.40%

Table 4.6 shows, post-test percentage of knowledge of minor disorders of newborn among post natal mothers overall post-test percentage of knowledge score is 82.40% among postnatal mothers.

Table 4.7: Posttest Level of Knowledge

Level of knowledge	No. of mothers	Percentage
Inadequate knowledge	0	0.0%
Moderate knowledge	11	18.3%
Adequate knowledge	49	81.7%
Total	60	100%

Table 4.7 shows the posttest level of knowledge of minor disorders of newborn among post natal mothers. In general none of the mothers were having inadequate knowledge and 18.3% of them having moderate knowledge and 81.7% of them were having adequate knowledge.

SECTION-C: DATA ON COMPARISON OF PRE ASSESSMENT AND POST ASSESSMENT KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS

Table-4.8: comparison of pretest and posttest knowledge score

s.no	Knowledge on	Pretest		Posttest		Mean Difference	Student's paired t-test
		Mean	SD	Mean	SD		
1	Vomiting	2.25	.93	4.28	1.06	2.03	t=13.88 P=0.001 *** DF= 59 , Significant
2	Diarrhoea	2.28	.80	4.13	1.11	1.85	t=12.82 P=0.001 *** DF= 59 , Significant
3	Constipation	2.55	.93	4.15	.90	1.6	t=10.36 P=0.001 *** DF= 59 , Significant
4	Napkin Rashes	2.10	.73	4.07	.90	1.97	t=14.41 P=0.001 *** DF= 59 , Significant
5	Physiological jaundice	1.60	.87	3.97	.78	2.37	t=16.15 P=0.001 *** DF= 59 , Significant

Table 4.8 shows the comparison of pretest and posttest knowledge score on minor disorders of newborn among post natal mothers.

Knowledge regarding

Vomiting, in pretest, mothers were having 2.25 score where as in posttest they were having 4.28 score. Difference is 2.03. This difference is large and it is statistically significant.

Diarrhoea, in pretest, mothers were having 2.28 score whereas in posttest they were having 4.13 score. Difference is 1.85. This difference is large and it is statistically significant.

Constipation, in pretest, mothers were having 2.55 score whereas in posttest they were having 4.15 score. Difference is 1.60. This difference is large and it is statistically significant.

Napkin Rashes, in pretest, mothers were having 2.10 score whereas in posttest they were having 4.07 score. Difference is 1.97. This difference is large and it is statistically significant.

Physiological jaundice, in pretest, mothers were having 1.60 score whereas in posttest they were having 3.97 score. Difference is 2.37. This difference is large and it is statistically significant.

Significance of difference between pretest and posttest score was calculated using student paired t-test.

Table-4.9: Comparison of overall knowledge score before and after planned teaching programme

	No. of postnatal mothers	**Pretest Mean± SD**	**Posttest Mean±SD**	**Mean difference Mean±SD**	**Student'S paired t-test**
Overall Knowledge Score	60	10.78 ± 2.94	20.60 ± 2.70	9.82 ± 2.57	t=29.532 P=0.001*** DF = 59, significant

*** very high significant at P≤0.001

Table 4.9 shows the comparison of overall knowledge score, before and after the administration of **Planned teaching programme**. On an average postnatal mothers were improved their knowledge from 10.78 to 20.60 after the administration of **PTP**. Pretest they were able to answer only 11 questions before administration of **PTP,** after administration of PTP they were able to answer upto 21 questions. Due to PTP they were able to answer 10 more questions correctly. This difference is statistically significant. Statistical significance was calculated by using student's paired 't'test.

Table-4.10: Each domain wise pretest and posttest percentage of knowledge

s. No	Domains	Posttest Knowledge	Pretest knowledge	Percentage of knowledge gain
1	Vomiting	85.60%	45.00%	40.60%
2	Diarrhoea	82.60%	45.60%	37.00%
3	Constipation	83.00%	51.00%	32.00%
4	Napkin Rashes	81.40%	42.00%	39.40%
5	Physiological jaundice	79.40%	32.00%	47.40%
	Overall	82.40%	43.12%	39.28%

Table 4.10 shows each domain wise knowledge gain score on knowledge regarding minor disorders of new born among postnatal mothers.

Table-4.11: Comparison of pretest and posttest level of knowledge score

Level of knowledge	Pretest		Posttest		Generalized McNemar's test
	n	%	N	%	
Inadequate knowledge	46	76.7%	0	0.0%	$\chi 2=54.76$ P=0.001***(S)
Moderate knowledge	14	23.3%	11	18.3%	
Adequate knowledge	0	0.0%	49	81.7%	
Total	60	100.0%	60	100.0%	

***significant at p<0.001 level

Table 4.11 shows the pretest and post-test level of knowledge score of minor disorders of newborn among postnatal mothers

Before PTP, 76.7% of the mothers were having inadequate level of knowledge score, 23.3% of them having moderate level of knowledge score and none of them were having adequate level of knowledge score.

After PTP, none of the mothers were having inadequate level of knowledge score, 18.3% of them having moderate level of knowledge score and 81.7% of them were having adequate level of knowledge score.

Level of knowledge gain of between pretest and posttest was calculated using Generalised McNemar's chisquare test.

SECTION-D: EFFECTIVENESS OF PLANNED TEACHING PROGRAMME ON SELECTED MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS.

Table-4.12: Effectiveness of planned teaching program and generalization of knowledge score

	Max score	**Mean score**	**Mean Difference of knowledge gain score with 95% Confidence interval**	**Percentage Difference of knowledge gain score with 95% Confidence interval**
Pretest	25	10.78	9.82(9.15 – 10.48)	39.28% (36.60% –41.92%)
Posttest	25	20.60		

Table 4.12 shows the effectiveness planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward at Institute of obstetrics and gynaecology and government hospital for women and children at Egmore in Chennai**.** On an average, in posttest after having PTP, mothers are gained 39.28% more knowledge score than pretest score.

Differences and generalization of knowledge gain score between pretest and posttest score was calculated using and mean difference with 95% CI and proportion with 95% CI.

SECTION-E: ASSOCIATION BETWEEN THE LEVEL OF PRETEST AND POSTTEST KNOWLEDGE WITH THE DEMOGRAPHIC VARIABLES OF POSTNATAL MOTHERS.

Table-4.13: Association between pretest level of knowledge and their demographic variables

Demographic variables		Pre-test level of knowledge score						Total	Chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Educational status of the mother	No formal education	11	84.6%	2	15.4%	0	0.0%	13	$\chi2$=5.31 P=0.15 (NS)
	Primary school	14	77.8%	4	22.2%	0	0.0%	18	
	Higher secondary school	14	87.5%	2	12.5%	0	0.0%	16	
	Graduate	7	53.8%	6	46.2%	0	0.0%	13	
Occupation	Houser wife	32	82.1%	7	17.9%	0	0.0%	39	$\chi2$=7.02 P=0.07 (NS)
	Self employee	8	80.0%	2	20.0%	0	0.0%	10	
	Professional	2	33.3%	4	66.7%	0	0.0%	6	
	Coolie	4	80.0%	1	20.0%	0	0.0%	5	
Monthly income	< Rs.2101	15	83.3%	3	16.7%	0	0.0%	18	$\chi2$=1.68 P=0.64 (NS)
	Rs.2102 – Rs. 6297	19	79.2%	5	20.8%	0	0.0%	24	
	Rs.6298 -- Rs.10495	7	63.6%	4	36.4%	0	0.0%	11	
	> Rs.10496	5	71.4%	2	28.6%	0	0.0%	7	
Religion	Hindu	35	74.5%	12	25.5%	0	0.0%	47	$\chi2$=1.10 P=0.57(NS)
	Muslim	3	100.0%	0	0.0%	0	0.0%	3	
	Christian	8	80.0%	2	20.0%	0	0.0%	10	
Residence	Rural	12	80.0%	3	20.0%	0	0.0%	15	$\chi2$=0.43 P=0.80 (NS)
	Urban	30	76.9%	9	23.1%	0	0.0%	39	
	Semi urban	4	66.7%	2	33.3%	0	0.0%	6	
Age of the child	0 -3 days	29	74.4%	10	25.6%	0	0.0%	39	$\chi2$=0.78 P=0.67 (NS)
	4 -6 days	15	78.9%	4	21.1%	0	0.0%	19	
	6 -9 days	2	100.0%	0	0.0%	0	0.0%	2	
	9 -12 days	0	0.0%	0	0.0%	0	0.0%	0	

Demographic variables		Pre-test level of knowledge score						Total	Chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age of the mother	18 -21 years	18	69.2%	8	30.8%	0	0.0%	26	$\chi 2$=2.02 P=0.56 (NS)
	22 - 25years	20	83.3%	4	16.7%	0	0.0%	24	
	25 – 29 years	6	75.0%	2	25.0%	0	0.0%	8	
	> 29 years	2	100.0%	0	0.0%	0	0.0%	2	
Mode of delivery	Normal vaginal delivery	26	68.4%	12	31.6%	0	0.0%	38	$\chi 2$=4.16 P=0.12 (NS)
	LSCS	16	88.9%	2	11.1%	0	0.0%	18	
	Forceps delivery	4	100.0%	0	0.0%	0	0.0%	4	
	Outside delivery	0	0.0%	0	0.0%	0	0.0%	0	
Weight of the baby	2 kg to 2.4 kg	4	80.0%	1	20.0%	0	0.0%	5	$\chi 2$=0.24 P=0.97 (NS)
	2.5kg to 2.8 kg	18	78.3%	5	21.7%	0	0.0%	23	
	2.9 kg to 3.4 kg	22	75.9%	7	24.1%	0	0.0%	29	
	More than 3.5kg	2	66.7%	1	33.3%	0	0.0%	3	

Table 4.13 shows the association between pretest level of knowledge and their demographic variables None of the demographic variables were significantly associated with their pretest level of knowledge score. Statistical significance was calculated using pearson chi square test.

Table-4.14: Association between Posttest Level of Knowledge and their Demographic Variables

Demographic variables		Post test level of Knowledge score						Total	Chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Educational status of the mother	No formal education	0	0.0%	5	38.5%	8	61.5%	13	χ^2=9.06 P=0.03* (S)
	Primary school	0	0.0%	5	27.8%	13	72.2%	18	
	Higher secondary school	0	0.0%	1	6.3%	15	93.7%	16	
	Graduate	0	0.0%	0	0.0%	13	100.0%	13	
Occupation	Houser wife	0	0.0%	6	15.3%	33	84.7%	39	χ^2=4.05 P=0.25 (NS)
	Self-employee	0	0.0%	3	30.0%	7	70.0%	10	
	Professional	0	0.0%	0	0.0%	6	100.0%	6	
	Coolie	0	0.0%	2	40.0%	3	60.0%	5	
Monthly income	< Rs.2101	0	0.0%	7	38.9%	11	61.1%	18	χ^2=7.82 P=0.05* (S)
	Rs.2102 – Rs. 6297	0	0.0%	3	12.5%	21	87.5%	24	
	Rs.6298 -- Rs.10495	0	0.0%	1	9.1%	10	90.9%	11	
	> Rs.10496	0	0.0%	0	0.0%	7	100.0%	7	
Religion	Hindu	0	0.0%	9	19.1%	38	80.9%	47	χ^2=0.93 P=0.62 (NS)
	Muslim	0	0.0%	1	33.3%	2	66.7%	3	
	Christian	0	0.0%	1	10.0%	9	90.0%	10	
Residence	Rural	0	0.0%	6	40.0%	9	60.0%	15	χ^2=6.73 P=0.03* (S)
	Urban	0	0.0%	4	10.3%	35	89.7%	39	
	Semi urban	0	0.0%	2	33.3%	4	66.7%	6	
Age of the child	0 -3 days	0	0.0%	7	17.9%	32	82.1%	39	χ^2=0.54 P=0.76 (NS)
	4 -6 days	0	0.0%	4	21.1%	15	78.9%	19	
	6 -9 days	0	0.0%	0	0.0%	2	100.0%	2	
	9 -12 days	0	0.0%	0	0.0%	0	0.0%	0	

Demographic variables		Post test level of Knowledge score						Total	Chi square test
		Inadequate		Moderate		Adequate			
		n	%	n	%	n	%		
Age of the mother	18 -21 years	0	0.0%	9	34.6%	17	65.4%	26	$\chi 2$=8.45 P=0.03*(S)
	22 - 25years	0	0.0%	2	8.3%	22	91.7%	24	
	25 – 29 years	0	0.0%	0	0.0%	8	100.0%	8	
	> 29 years	0	0.0%	0	0.0%	2	100.0%	2	
Mode of delivery	Normal vaginal delivery	0	0.0%	7	18.4%	31	81.6%	38	$\chi 2$=1.08 P=0.58 (NS)
	LSCS	0	0.0%	4	22.2%	14	77.8%	18	
	Forceps delivery	0	0.0%	0	0.0%	4	100.0%	4	
	Outside delivery	0	0.0%	0	0.0%	0	0.0%	0	
Weight of the baby	2 kg to 2.4 kg	0	0.0%	1	20.0%	4	80.0%	5	$\chi 2$=0.80 P=0.84(NS)
	2.5kg to 2.8 kg	0	0.0%	4	17.4%	19	82.6%	23	
	2.9 kg to 3.4 kg	0	0.0%	6	20.7%	23	79.3%	29	
	More than 3.5kg	0	0.0%	0	0.0%	3	100.0%	3	

Table no 4.14 shows the association between post-test level of knowledge and their demographic variables. More educated mothers, Urban area mothers, more income mothers, Elder age mothers were gained more knowledge score than others. Statistical significance was calculated using pearson chi square test.

Table-4.15: Association between Knowledge Gain Score and Demographic Variables

Demographic variables		Knowledge gain score						Total	Oneway ANOVA F-test/t-test
		Pre test		Post test		Gain score=Post-Pre			
		Mean	SD	Mean	SD	Mean	SD		
Educational status of the mother	No formal education	10.08	2.78	19.3	2.16	9.22	3.38	13	F=2.81 P=0.04* (S)
	Primary school	10.78	2.76	19.72	2.42	8.94	1.73	18	
	Higher secondary school	10.13	2.70	20.94	2.77	9.81	2.46	16	
	Graduate	12.31	3.35	22.23	1.92	10.92	2.63	13	
Occupation	Houser wife	10.64	2.76	20.31	2.54	9.67	2.57	39	F=0.54 P=0.65 (NS)
	Self employee	9.20	2.74	19.80	3.01	10.60	2.67	10	
	Professional	14.00	2.45	24.17	.98	10.17	1.83	6	
	Coolie	11.20	2.95	20.20	1.79	9.00	3.46	5	
Monthly income	< Rs.2101	10.33	3.27	18.22	1.77	7.89	2.59	18	F=4.07 P=0.01** (S)
	Rs.2102 – Rs. 6297	10.54	2.75	18.75	2.86	8.21	2.98	24	
	Rs.6298 -- Rs.10495	11.91	2.51	22.36	3.44	10.45	2.25	11	
	> Rs.10496	11.00	3.46	22.86	3.08	11.86	1.35	7	
Religion	Hindu	10.83	3.07	20.79	2.76	9.96	2.66	47	F=0.35 P=0.70(NS)
	Muslim	9.67	2.08	19.33	3.06	9.67	1.53	3	
	Christian	10.90	2.69	20.10	2.42	9.20	2.49	10	
Residence	Rural	10.67	2.41	19.20	2.51	8.53	2.03	15	F=3.96 P=0.02* (S)
	Urban	10.77	3.06	21.29	2.91	10.52	2.42	39	
	Semi urban	11.17	3.76	20.81	1.79	9.64	3.07	6	
Age of the child	0 -3 days	10.00	2.79	20.44	2.77	10.44	2.46	39	F=0.54 P=0.76 (NS)
	4 -6 days	10.63	3.24	20.63	2.59	10.00	2.08	19	
	6 -9 days	9.00	2.83	23.50	1.71	14.50	3.54	2	

Demographic variables		Knowledge gain score						Total	Oneway ANOVA F-test/t-test
		Pre test		Post test		Gain score=Post-Pre			
		Mean	SD	Mean	SD	Mean	SD		
Age of the mother	18 -21 years	11.23	3.00	19.31	2.65	8.08	2.63	26	F=2.84 P=0.05* (S)
	22 - 25years	10.63	2.48	19.76	2.44	9.13	2.74	24	
	25 – 29 years	10.13	4.12	20.91	3.82	10.78	2.26	8	
	> 29 years	9.50	3.54	20.82	2.12	11.32	1.41	2	
Mode of delivery	Normal vaginal delivery	11.11	3.29	20.58	2.86	9.47	2.59	38	F=1.05 P=0.35 (NS)
	LSCS	10.39	2.17	20.67	2.70	10.28	2.65	18	
	Forceps delivery	9.50	2.38	20.50	1.00	11.00	1.83	4	
	Outside delivery	.	.	.	.	.	.	0	
Weight of the baby	2 kg to 2.4 kg	11.00	2.65	20.40	2.61	9.40	.89	5	F=0.90 P=0.45 (NS)
	2.5kg to 2.8 kg	10.39	2.97	20.74	2.58	10.35	2.85	23	
	2.9 kg to 3.4 kg	10.97	3.08	20.62	2.96	9.66	2.30	29	
	More than 3.5kg	11.67	2.89	19.67	2.08	8.00	4.58	3	

Table no 4.15 shows the association between level of knowledge gain score and their demographic variables. More educated mothers, Urban area mothers, more income mothers, Elder age mothers were gained more knowledge score than others. Statistical significance was calculated using one way analysis of variance F-test and student independent t-test.

CHAPTER-V
DISCUSSION

This chapter deals with the discussion of the results of the data analyzed based on the objectives of the study and the hypothesis. The purpose of the study is "To evaluate the effectiveness of (PTP) on knowledge of selected minor disorders of newborn among postnatal mothers in Institute of Obstetrics and Gynaecology, Egmore".

Findings based on the objectives

Objective-1: To assess the pretest knowledge of postnatal mothers regarding selected minor disorders of newborn.

In assessing the pretest percentage of knowledge regarding selected minor disorders of newborn among postnatal mothers, each domain the mother's has scored percentage of vomiting (45%), diarrhea (45.60%), constipation (51.00 %), napkin rashes (42.00%), physiological jaundice (32.00%), they are having maximum knowledge in constipation of (51.00%) and minimum knowledge score in physiological jaundice (32.00%). Overall pretest percentage of knowledge score is (43.12 %) among postnatal

The study findings revealed that the level of knowledge of minor disorders of newborn among 60 post natal mothers who met in the inclusion criteria and mothers were observed with the structured questionnaire and responses. In pretest, considering the level of knowledge of minor disorders of newborn among postnatal mothers 46 (76.7%) were having adequate knowledge and 14(23.3%) were having moderate knowledge and none of them were having adequate knowledge score. There is no statistically significant difference of knowledge score.

The above findings were supported by the study conducted by the author **Venu.A.S, NaveenKumar P.R,et,al., (2016)**. Their study results shows, the majority of the postnatal mothers had average pretest knowledge scores that is 29 (99%) and average knowledge and 1(1%) had poor knowledge regarding common minor neonatal problems and its management.

Objective-2: To assess the effectiveness of planned teaching programme on selected minor disorders of newborn among postnatal mothers.

In assessing the posttest percentage of knowledge regarding selected minor disorders of newborn among postnatal mothers, each domain the mother's has scored percentage of vomiting (85.60%), diarrhea (82.60%), constipation (83.00 %), napkin rashes (81.40%), physiological jaundice (79.40%), they are having maximum knowledge in vomiting (85.60%) and minimum knowledge score in physiological jaundice (79.40%). Overall posttest percentage of knowledge score is (82.40 %) among postnatal mothers.

In posttest, considering the level of knowledge of minor disorders of newborn among postnatal mothers, none are having inadequate level of knowledge, 11(18.3%) of them are having moderate level of knowledge and 49(81.7%) of them are having adequate level of knowledge score.

The study compared overall pre-test and post-test level of knowledge. In considering the pre-test, mean value mothers had 10.78 score, whereas in post-test the mothers has 20.60 score, so the mean difference is 9.82, hence the difference between pretest and posttest score is large and it is statistically significant. Statistical significance was calculated by using paired t test.

To evaluate the effectiveness of planned teaching programme the pretest and posttest values are compared. The calculated‘t’ value is greater than the tabulated value at 5% level of significance. It shows that the teaching was effective.

The above findings were supported by the study conducted by the author **Venu.A.S, NaveenKumar P.R,et,al., (2016).** Their study results shows that the mean knowledge scores in pre-test were 1.32 and SD was 0.469 and in post-test mean was 1.52 and SD was 0.499. So, it is evident that mean post-test knowledge score of primi mothers were significantly greater than their mean pre-test knowledge score. $t'_{\{1199\}} = 10.572$ at $P < .005$ level of significance.

Thus, hypothesis H_1 states, there is a significant difference between the pretest and posttest level of knowledge on selected minor disorders of newborn among postnatal mothers was accepted

Objective-3: To determine the association between pretest and posttest knowledge scores on selected minor disorders of newborn with their selected demographic variables.

In considering the mother’s education status, more educated mothers have 10.92 % gained knowledge score. P value is 0.04. This is statistically significant.

In considering the monthly income, more than Rs.10496 groups of family getting 11.86%, and Rs.6298 – Rs.10495 groups of family getting 10.45% were gained knowledge score.This is statistically significant.

In considering the residence, urban people have 10.52% gained knowledge score. This is also statistically significant.

In considering the age of the mother, more than 29 years of age group were gained knowledge score of 11.32% and 25 – 29 years of age

group were gained knowledge score of 10.78%. This is statistically significant.

The study associated between the post-test level of knowledge on minor disorders of new-born among postnatal mothers with their demographic variables is statistically significance was calculated by using one way ANOVA F test and student independent t-test.

Thus the hypothesis $H_{2\ which}$ states that there is a significant association between the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers with their selected demographic variables such as more educated mothers, urban area mothers, more income group mothers, elder age mothers had gained more knowledge score than the others. None of the other variables are not significant. Hence the H_2 was accepted.

CHAPTER-VI
SUMMARY, IMPLICATION, LIMITATION, RECOMMENDATION AND CONCLUSION

This chapter deals with summary, implications, limitations, recommendations and conclusion of the study.

6.1 SUMMARY

The study to assess the effectiveness of PTP on knowledge of minor disorders of newborn among postnatal mothers were conducted in the Institute of Obstetric and Gynaecology and Government Hospitals for Women and Children at Chennai. The study was conducted in postnatal ward for a period of 4 weeks. The aim of the study was to assess the level of knowledge among postnatal mothers regarding minor disorders of newborn before and after giving the planned teaching program. A conceptual framework for this study was adapted by Wiedenbach Helping art theory. The first part of the study was involved with instruments developed based on the findings from a quantitative study. Semi-structured questionnaires were developed. A pilot study was done to assess the feasibility of the study and necessary changes were adopted after pilot study reliability of the tool was assessed by using Test – retest method. Knowledge score reliability correlation coefficient value is 0.86. The investigators were chosen for the pre experimental study, one group pretest and post-test design. The subjects were selected using convenient sampling technique. Subject's knowledge was assessed before giving the planned teaching program.

6.2 MAJOR FINDING OF THE STUDY

6.2.1. Based on demographic findings

- With regard to **educational status** of the mother, majority of postnatal mothers (30.0%) were in primary school education and

minority (21.7 %) were in the no formal education and also belongs to Graduate group people.

- Regarding **occupation,** majority of the postnatal mothers (65%) were belongs to house wife and lower most (8.3%) were coolie.

- About **monthly income**, majority of the postnatal mothers (40.0%) were belongs to categories of Rs, 2102 – Rs. 6297 and (11.7%) were lowest categories of more than Rs. 10496.

- With regard to **religion** majority of the highest group postnatal mothers (78.3%) were belongs to Hindu group family, and the lowest group (5.0 %) were belong to Christian family.

- With regard to **place of residence**, the majority of the postnatal mothers (65%) were urban and (10%) were semi urban .

- Regarding **age of the child,** majority highest group of the neonates belongs to the postnatal mother neonates were 0 – 3 days are (65.0%) and lowest age group of neonates were 6 – 9 days were (3.3%)

- Regarding **age of the mothers**, majority of the postnatal mothers were 18 – 21 years of the age were (43.3%) and the lowest age group were more than 29 years of the age are (3.3%)

- With regard to **mode of delivery**, the majority of postnatal mothers (63.3%) were normal vaginal delivery and least group of postnatal mothers (6.7 %) were forceps delivery.

6.2.2. Before PTP

Before planned teaching programme 76.7% of the mothers were having inadequate level of knowledge score, 23.3% of them having

moderate level of knowledge score and none of them are having adequate level of knowledge score.

After PTP

After planned teaching programme none of the mothers are having inadequate level of knowledge score, 18.3% of them having moderate level of knowledge score and 81.7% of them are having adequate level of knowledge score

6.2.3. Based on comparison between pretest and posttest using paired t-test

The study compared that the pretest and posttest level of knowledge score on minor disorders of newborn among postnatal mothers.

Knowledge regarding

Vomiting, in pretest, mothers are having 2.25 score whereas in posttest they are having 4.28 score. Difference is 2.03. This difference is large and it is statistically significant.

Diarrhoea, in pretest , mothers are having 2.28 score whereas in posttest they are having 4.13 score. Difference is 1.85. This difference is large and it is statistically significant.

Constipation, in pretest , mothers are having 2.55 score whereas in posttest they are having 4.15 score. Difference is 1.60. This difference is large and it is statistically significant.

Napkin Rashes, in pretest , mothers are having 2.10 score whereas in posttest they are having 4.07 score. Difference is 1.97. This difference is large and it is statistically significant.

Physiological jaundice, in pretest , mothers are having 1.60 score whereas in posttest they are having 3.97 score. Difference is 2.37 . This difference is large and it is statistically significant.

Significance of difference between pretest and posttest score was calculated using student paired t-test.

6.2.4. Findings based on effectiveness of PTP among postnatal mothers

The study revealed that the **effectiveness** planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward at Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children at Egmore in Chennai**.** In posttest after having PTP, mothers are gained 39.28% more knowledge score than pretest score. Differences and generalization of knowledge gain score between pretest and posttest score was calculated using and mean difference with 95% CI (confidence interval) and proportion with 95% CI (confidence interval), none of the mothers are inadequate knowledge, statistically shows overall knowledge in posttest score is 82.40%.

6.2.5. Findings based on association between posttest level of knowledge and their demographic variables

In education status of the mothers, graduate's gained more knowledge score about 100.0%, and no formal education group gained knowledge score of 61.5%, P value is 0.03, hence its statistically significant.

In place of living, postnatal mothers living in Urban area gained more knowledge score about 89.7%, and those living in rural area gained knowledge score of 60.0%, P value is 0.03, hence its statistically significant.

In monthly family income, more than Rs.10496 gained more knowledge score about 100.0%, and those income of less than Rs.2101 gained knowledge score of 61.1%, P value is 0.05, hence its statistically significant

In considering the age, above 25 years of age group gained more knowledge score about 100.0% , more than 18 years of age group gained knowledge score of 65.4%, P value is 0.03, hence its statistically significant.

6.3 IMPLICATION OF THE STUDY

The findings of the study have implications in various areas of Nursing like, Nursing Administration, Nursing practice, Nursing research and Nursing education, regarding increase in the knowledge of minor disorders of newborn among postnatal mothers.

6.3.1 Nursing education

Providing planned teaching programme must be emphasized in the nursing curriculum, so that the nursing students will be aware of the importance of providing knowledge through PTP regarding minor disorders of newborn. It is one of the inexpensive measures one can easy to administer in the practice. This non- pharmacological management should be create awareness among the students through seminars and workshops. Benefits of this intervention and condition to apply this intervention clearly taught to the midwifery nursing students both diploma and graduate level. Health education programmes can be conducted by the students to the dais and village health nurse regarding importance of identification of minor disorders and its preventive measures, so that they can early hospitalized the newborn in order to reduce neonatal morbidity and mortality rate.

6.3.2. Nursing Practice

Unrealistic fears based on misinformation and misconception can be prevented by factual information and knowledge. The personnel are in the best position impart the PTP in the hospital. So they should plan and impart PTP according to the need of primi mothers. Nursing personnel should be given in- service education to update their knowledge regarding prevention and management of minor disorders.

6.3.3. Nursing Administration

The quality of health care services mainly depends on the good administration. The good administrator role implication of the effective communication and updating knowledge. The administrator can arrange the in- service education programme and nursing conferences to promote this intervention of prevention and management of minor disorders of newborn. The community health administrator can also communicate this method to the village health nurses and dais.

6.3.4. Nursing Research

Research should be continued on need of the practices and method of teaching focusing on prevention and management of selected minor disorders of newborn.

6.4. LIMITATION

This study is limited to the primi postnatal mothers who are in the selected setting. Generalization is limited to selected setting include in the study. An increase sample size and duration of the study would be an over all measure to assess the effectiveness of planned teaching programme.

6.5. RECOMMENDATION

1) The administration of PTP during antenatal period by the health professional can be very effective.

2) The village health nurse can conduct the educational programme on neonatal minor disorders during their postnatal visit.

3) The nursing students in their posting they can create awareness regarding prevention and management of minor disorders of newborn.

6.6 CONCLUSION

The findings of the study recommended that the prevention and management of selected minor disorders of newborn. Special health education related to the prevention and management of selected minor disorders and early hospitalization and prevents the occurrence of neonatal complications. Educating mothers and providing them correct information can help them to alleviate the fear and more effectiveness on mothers knowledge of hygiene and preventive measures, neonatal complications and follow up care during post natal period. The present study proved that planned teaching programme was effective among the postnatal mother.

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SEMI STRUCTURE QUESTIONNAIRE
TOOL-I DEMOGRAPHIC VARIABLE

Instructions to the Participant You are requested to provide certain information about yourself, kindly give ( ) mark the correct response.The information given by you will be kept confidential and used only for study purpose.

1. Educational status of the mother
   a. No formal education
   b. Primary school
   c. Higher secondary school
   d. Graduate

2. Occupation
   a. House wife
   b. Self employee
   c. Professional
   d. Coolie.

3.Monthly income
   a. less than equal to 2101
   b. Rs.2102 – Rs. 6297
   c. Rs.6298 -- Rs.10495
   d. more than Rs.10496

4.Religion
   a. Hindu
   b. Muslim
   c. Christian

5. Residence
   a. Rural
   b. Urban
   c. Semi urban

6.Age of the child
   a. 0 – 3 days
   b. 3 – 6 days
   c. 6 – 9days
   d. 9 – 12days

7. Age of the mother
   a. 18 -21 years
   b. 22 - 25years
   c. 25 – 29 years
   d. more than 29 years

8. Mode of delivery
   a. Normal vaginal delivery
   b. LSCS
   c. Forceps delivery
   d. Outside delivery

9. Weight of the baby
   a. 2 kg to 2.4 kg
   b. 2.5kg to 2.8 kg
   c. 2.9 kg to 3.4 kg
   d. More than 3.5kg

TOOL-II SEMI STRUCTURED INTERVIEW SCHEDULE ON KNOWLEDGE REGARDING MINOR DISORDERS OF NEWBORN

1.What is vomiting?
   a. Bring out liquid(milk)soon after feeds
   b. Bring out saliva soon after feeds
   c. Bring out air soon after feeds
   d. Don't know

2. What are the causes of vomiting?
   a. Inadequate breast milk
   b. Faulty feeding technique
   c. Difficulty in breathing
   d. Don't know

3.What are the following action to be done after feeding?
   a. Initiate the baby to sleep
   b. Keep the baby to be happy
   c. Wipe the baby 's mouth and burp the baby
   d. Don't know

4.How to prevent vomiting?
   a. Proper feeding technique & leave the baby in the cradle
   b. Make to sit upon the lap & burp for 5 to 10 min after feed
   c. Make to put prone position & burp for 5 to 10 min after feed
   d. Don't know

5.What you will do for prevention of aspiration?

a. Holding the baby upright position
b. Holding the baby forward position
c. Change alternate supine & prone position.
d. Don't know

6.What is Diarrhoea?

a. Loose watery stools(6) and more times
b. Loose watery stools once
c. Mucus in the stool
d. Blood in the stool

7.What. causes diarrhoea?

a. Bottle feeding
b. Breast feeding
c. Intake of warm water
d. Don't know

8. Which one of the following is the risk factor for diarrhea?

a. Inadequate ventilation
b. Over crowding
c. Poor hygienic practice
d. Don't know

9.What should you do for diarrhea?

a. Give liquids (warm water)
b. Give grape water
c. Give breast milk
d. Don't know

10.Which one of the following is the ill effect of bottle feeding?

a. Baby will develop abdominal pain.
b. Baby will develop constipation
c. Baby will develop diarrhea
d. Don't know

11.What is constipation?

a. Baby pass soft stool
b. Baby pass hard & dry stool
c. Baby pass semi solid stool
d. Don't know

12. What are the causes for constipation?
    a. Inadequate Breast feeding
    b. Inadequate artificial feeding
    c. More sleep
    d. Don't know

13. Which one is preferred food to newborn babies during constipatiuon?
    a. Breast milk
    b. Cow milk
    c. Goat milk
    d. Don't know

14. What are the preventive measures for constipation?
    a. To give medicated laxative
    b. To give more breast milk
    c. To give bottle milk
    d. Don't know

15. How will you manage severe constipation?
    a. To be treated by grand mother
    b. To be treated in hospital
    c. To be treated in home itself
    d. Don't know

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16. What is mean by napkin rashes?
    a. It is a form of contact dermatitis
    b. It is produced by heat
    c. It occurs due to unhygienic practice
    d. Don't know

17. What are the causes of napkin rashes?
    a. Prolonged contact with urine and faces
    b. Tight fitting diapers
    c. Infections
    d. Don't know

18. How will you manage the napkin rashes?
    a. Clean ,dry , expose to air& apply coconut oil.
    b. Clean and apply talcum powder
    c. After cleaning the motion apply dressing
    d. Don't know

19. How many times you change the napkin or diaper in a day?
    a. Three times in a day
    b. Four times in a day
    c. Whenever wetness is found
    d. Don't know

20. What are the home care for napkin rashes?
    a. Keep the skin dry
    b. Skin should not be in contact with urine & stool for long times
    a. Wash the napkin area with warm water
    b. All the above.

21. What is physiological jaundice?
    a. Yellow discolouration all over the baby
    b. Yellow discolouration found only on the eye
    c. Yellow discolouration found in palms & soles.
    d. Don't know

22. When do physiological jaundice develop?
    a. 2 to 9 days
    b. 9 to 16 days
    c. 16 to 23 days
    d. Don't know

23. How to manage the baby with physiological jaundice?
    a. Expose the baby to early morning sunlight for about 10 to 20 min
    b. Expose the baby to sunlight for about 10 to 20 min after 10 am
    c. Can expose the baby to sunlight at any time.
    d. Don't know

24. What are the dangerous effect of jaundice that need medical consultation?
    a. Persisting jaundice more than 14 days
    b. Passing dark coloured urine
    c. Passing pale or chalky white coloured stool
    d. Above the all.

25. What measures the mother has to take care of physiological jaundice occur?
    a. Provide more breast milk
    b. Expose the baby to early morning sunlight
    c. Routinely monitor the baby skin, sclera, stool & urine.
    d. Above the all.

KEY ANSWER

1.	a.	6.	a.	11.	b.	16.	c.	21.	a.
2.	b.	7.	a.	12.	a.	17.	a.	22.	b.
3.	c.	8.	c.	13.	a.	18.	a.	23.	a.
4.	b.	9.	c.	14.	b.	19.	c.	24.	d.
5.	a.	10.	c.	15.	b.	20.	d.	25.	d.

e.

தாய்மார்களின் சுய விபரம்

தாய்மார்களை பற்றிய தகவல்களை கீழ்கண்டவற்றில் உள்ள கேள்விகளில் உங்களது விபரங்களை (✓) இந்த குறியீட்டில் குறிக்கவும்.

1) தாயின் கல்வி நிலை

அ) படிக்கவில்லை ☐

ஆ) ஆரம்பக்கல்வி ☐

இ) உயர்நிலைக் கல்வி ☐

ஈ) கல்லூரி படிப்பு ☐

2) தொழில்

அ) இல்லத்தரசி ☐

ஆ) சுய ஊழியர் ☐

இ) தொழில்முறை ☐

ஈ) கூலி ☐

3) மாத வருமானம்

அ) ரூ.2101க்கும் குறைவு ☐

ஆ) ரூ.2101-ரூ.6297 ☐

இ) ரூ.6298- ரூ.10495 ☐

ஈ) ரூ.10496க்கும் மேல் ☐

4) மதம்

அ) இந்து மதம் ☐

ஆ) முஸ்லிம் மதம் ☐

இ) கிறிஸ்தவ மதம் ☐

ஈ) மற்றவர்கள் ☐

5) குடியிருப்புகள்

அ) கிராமப்புறம் ☐

ஆ) நகர்ப்புறம் ☐

இ) கிராம நகர்ப்புறம் ☐

ஈ) மற்ற மாநிலம் ☐

6) குழந்தையின் வயது

அ) 0-3 நாட்கள் ☐

ஆ) 3-6 நாட்கள் ☐

இ) 6-9 நாட்கள் ☐

ஈ) 9-12 நாட்கள் ☐

7) தாயின் வயது

அ) 18-21 ஆண்டுகள் ☐

ஆ) 22-25 ஆண்டுகள் ☐

இ) 25-29 ஆண்டுகள் ☐

ஈ) 29க்கும் மேற்பட்ட ஆண்டுகள் ☐

8) பிரசவம் எப்படி நடைபெற்றது

அ) சுகப்பிரசவம் ☐

ஆ) அறுவை சகிச்சை ☐

இ) ஆயுத பிரசவம் ☐

ஈ) துரியபடுத்தின சுகப்பிரசவம் ☐

9) குழந்தையின் எடை

அ) 2.0 முதல் 2.4 கிலோ வரை ☐

ஆ) 2.5 முதல் 2.8 கிலோ வரை ☐

இ) 2.9 முதல் 3.4 கிலோ வரை ☐

ஈ) 3.5 கிலோவுக்கும் மேல் ☐

பச்சிளங்குழந்தைகளின் சிறு உபாதைகள் பற்றி அறிவுத்திறனை சோதித்து அறிதல்

I.வாந்தி

1) வாந்தி என்றால் என்ன?

அ) உணவளித்த பிறகு விரைவில் பால் வெளிவருதல் ☐

ஆ) உணவளித்த பிறகு விரைவில் உமிழ்நீர் வெளிவருதல் ☐

இ) உணவளித்த பிரகு விரைவில் காற்றினை வெளியே கொண்டுவர வைத்தல் ☐

ஈ) தெரியாது ☐

2) வாந்தி எடுப்பதற்கான காரணங்கள் யாவை?

அ) குறைவாக தாய்ப்பால் கொடுத்தல் ☐

ஆ) தவறான முறையில் தாய்ப்பால் கொடுத்தல் ☐

இ) மூச்சுத்திணறல் ஏற்படுதல் ☐

ஈ) தெரியாது ☐

3) தாய்ப்பால் கொடுத்த பிறகு என்ன செய்ய வேண்டும்?

அ) குழந்தையை தூங்க வைக்க வேண்டும் ☐

ஆ) குழந்தையை மகிழ்ச்சியாக இருக்க வைக்க வேண்டும் ☐

இ) குழந்தையின் வாயினை துடைத்து, ஏப்பம் வரை செய்ய வேண்டும் ☐

ஈ) தெரியாது ☐

4) எப்படி வாந்தியினை தடுக்க வேண்டும்?

அ) முறையான வழியில் உணவு கொடுத்த் பிறகு தொட்டிலில் குழந்தையை விடவும் ☐

ஆ) தாய்ப்பால் கொடுத்த பின்பு மடியில் உட்காரவைத்து 5 முதல் 10 நிமிடம் வரை ஏப்பம் வர செய்யவும் ☐

இ) தாய்ப்பால் கொடுத்த பின்பு 5 முதல் 10 நிமிடம் வலுவான நிலையில் குழந்தையை வைக்க வேண்டும் ☐

ஈ) தெரியாது ☐

5) நீங்கள் புரையேறுதலை தடுப்பதற்கு என்ன செய்வீர்கள்?

அ) குழந்தையை நிமிர்ந்த நிலையில் வைத்திருத்தல் ☐

ஆ) குழந்தையை முன்னோக்கி நிலையில் வைத்திருத்தல் ☐

இ) மல்லாந்து படுத்திருக்கிற நிலையிலும் மற்றும் குப்புற படுத்த நிலையிலும் குழந்தை இடங்களை மாறி மாறி வைத்திருத்தல் ☐

ஈ) தெரியாது ☐

6) வயிற்றுப்போக்கு என்றால் என்ன?

அ) நீர் போன்ற மலம் அடிக்கடி போதல் ☐

ஆ) நீர் போன்ற மலம் ஒரே ஒரு முறை போதல் ☐

இ) மலத்தில் சளி இருத்தல் ☐

ஈ) மலத்தில் இரத்தம் இருத்தல் ☐

7) வயிற்றுப்போக்கு ஏற்பட காரணம் என்ன?

அ) புட்டிப்பால் உணவு ☐

ஆ) தாய்ப்பால் உணவு ☐

இ) கூடான நீர் உட்கொள்ளுதல் ☐

ஈ) தெரியாது ☐

8) வயிற்றுப்போக்கு ஆபத்து காரணி பின்வரும் ஒன்றாகும்?

அ) போதுமான காற்றோட்டம் இன்மை ☐

ஆ) அதிக நேரிச்சல் ☐

இ) சுத்தமின்மையால் ஏற்படும் பழக்கவழக்கங்கள் ☐

ஈ) தெரியாது ☐

9) வயிற்றுப்போக்கின் பொழுது நீங்கள் என்ன செய்ய வேண்டும்?

அ) திரவங்களை (வெதுவெதுப்பான நீர்) கொடுக்க வேண்டும் ☐

ஆ) கிரேப் வாட்டர் கொடுக்க வேண்டும் ☐

இ) தாய்ப்பால் கொடுக்க வேண்டும் ☐

ஈ) தெரியாது ☐

10) புட்டிப்பால் கொடுப்பதினால் வரும் மோசமான விளைவுகள் யாவை?

அ) குழந்தைக்கு வயிற்று வலி ☐

ஆ) குழந்தைக்கு மலச்சிக்கல் வரும் ☐

இ) குழந்தைக்கு வயிற்றுப்போக்கு உருவாகும் ☐

ஈ) தெரியாது ☐

11) மலச்சிக்கல் என்றால் என்ன?

அ) குழந்தை மென்மையாக மலம் கழியும் ☐

ஆ) குழந்தை கடினமான மற்றும் காய்ந்து, சிரமப்படும் மலம் கழியும் ☐

இ) குழந்தை அரைதிடமாக, பாதியாக மலம் கழியும் ☐

ஈ) தெரியாது ☐

12) மலச்சிக்கல் ஏற்படுவதற்கான காரணங்கள் யாவை?

அ) தேவைக்கு மிகவும் குறைவாக தாய்ப்பால் கொடுத்தல் ☐

ஆ) தேவைக்கு மிகவும் குறைவாக புட்டிப்பால் கொடுத்தல் ☐

இ) தேவைக்கு மிகவும் அதிகமாக தூங்குதல் ☐

ஈ) தெரியாது ☐

13) மலச்சிக்கலின் போது பச்சிளங்குழந்தைக்கு கொடுக்கப்படும் உணவு எது?

அ) தாய்ப்பால் ☐

ஆ) மாட்டுப்பால் ☐

இ) ஆட்டுப்பால் ☐

ஈ) தெரியாது ☐

14) மலச்சிக்கலினை எப்படி தடுக்க வேண்டும்?

அ) மருந்து மெழுகினை மலவாயிடத்தில் வைக்க வேண்டும் ☐

ஆ) அதிகமாக தாய்ப்பாலினை கொடுக்க வேண்டும் ☐

இ) அதிகமா புட்டிப்பாலினை கொடுக்க வேண்டும் ☐

ஈ) தெரியாது ☐

15) கடுமையான மலச்சிக்கலை நீங்கள் எவ்வாறு நிர்வகிப்பீர்கள்?

அ) பாட்டி வைத்தியத்தின் மூலம் சிகிச்சை செய்யப்பட வேண்டும் ☐

ஆ) மருத்துவமனையில் சிகிச்சை செய்யப்பட வேண்டும் ☐

இ) வீட்டில் இருந்தபடியே சிகிச்சை செய்யப்பட வேண்டும் ☐

ஈ) தெரியாது ☐

16) நாப்கின் புண் என்றால் என்ன?

அ) இது தொடர்பினால் அமையக்கூடிய தோல் அலர்ஜி ☐

ஆ) அதிக வெப்பத்தினால் வரக்கூடியது ☐

இ) சுகாதாரமற்ற பழக்கத்தினால் வரக்கூடியது ☐

ஈ) தெரியாது ☐

17) நாப்கின் புண் உண்டாவதற்கான முழுமையான காரணம் என்ன?

அ) நெடு நேரத்திற்கு மலம் மற்றும் சிறுநீர் படுவதினால் ☐

ஆ) மிகவும் நெருக்கமான நாப்கின் பயன்படுத்துவதினால் ☐

இ) நோய் தொற்றினால் ☐

ஈ) தெரியாது ☐

18) குழந்தைக்கு நாப்கின் புண் வந்தால் என்ன செய்வீர்கள்?

அ) சுத்தம் செய்து, உலர்ந்த பின் தேங்காய் எண்ணெய் பயன்படுத்துவதி காற்று வெளிப்படவைத்த ☐

ஆ) சுத்தமான பிறகு நாப்கின் புண் மேல் பவுடர் போடுவது ☐

இ) மலத்தினை சுத்தம் செய்த பின் மருத்துவ மருந்தினை பயன்படுத்துவது ☐

ஈ) தெரியாது ☐

19) ஒரு நாளைக்கு எத்தனை முறை நாப்கின் மாற்றுவீர்கள்?

அ) ஒரு நாளைக்கு 3 முறை ☐

ஆ) ஒரு நாளைக்கு 4 முறை ☐

இ) ஈரமாக இருக்கும்போதெல்லாம் மாற்றுவது ☐

ஈ) தெரியாது ☐

20) நாப்கின் புண் வராமல் இருக்க தடுக்கும் முறைகள்?

அ) அதிக நேரம் சிறுநீரில் அல்லது மலத்தில் குழந்தையின் தோல் படாமல் இருத்தல் ☐

ஆ) குழந்தையின் பின்புறத்தை நன்கு துடைத்து ஈரப்பதம் இல்லாமல் வைத்திருக்க வேண்டும் ☐

இ) மிதமான வெந்நீரில குழந்தையின் பின் புறத்தை கழுவ வேண்டும் ☐

ஈ) மேற்கண்ட அனைத்தும் ☐

21) உடலியல் மஞ்சள் காமாலை என்றால் என்ன?

அ) குழந்தையின் மீது மஞ்சள் நிறத்திலான நிறமற்ற உடல் முழுவதும் காணப்படுவது ☐

ஆ) மஞ்சள் நிறமாற்றம் கண்ணில் மட்டுமே காணப்படுவது ☐

இ) மஞ்சள் நிறமாற்றம் கை மற்றும் கால் பாதங்களில் காணப்படுவது ☐

ஈ) தெரியாது ☐

22) உடலியல் மஞ்சள் காமாலை எப்போது உருவாகும்?

அ) 2 முதல் 9 நாட்கள் ☐

ஆ) 9 முதல் 16 நாட்கள் ☐

இ) 16 முதல் 23 நாட்கள் ☐

ஈ) தெரியாது ☐

23) பச்சிளங் குவந்தைக்கு உடலில் மஞ்சள் காமாலை இருந்தால் என்ன செய்ய வேண்டும்?

அ) குழந்தையை தினமும் விடியற் காலையில் சூரிய ஒளி படும்படி 10 முதல் 20 நிமிடம் காண்பிப்பது ☐

ஆ) குழந்தையை தினமும் 10 மணிக்கு மேல் சூரிய ஒளி படும்படி காண்பிப்பது ☐

இ) குழந்தையை தினமும் எப்போது வேண்டுமானாலும் 10 நிமிடம் சூழிய ஒளி படும்படி காண்பிப்பது ☐

ஈ) தெரியாது ☐

24) மருத்துவ ஆலோசனை தேவைப்படும் மஞ்சள் காமாலை ஆபத்தான விளைவு என்ன?

அ) தொடர்ந்து மஞ்சள் காமாலை 14 நாட்களுக்கு மேல் நீடித்தல் ☐

ஆ) சிறுநீர் கழிக்கும்போது மிகவும் அடர்ந்த மஞ்சல் நிறத்தில் இருத்தல் ☐

இ) மலம் கழிக்கும்போது வெளிர் அல்லது சாக்லேட் வெள்ளை நிறத்தில் இருத்தல் ☐

ஈ) மேற்கண்ட அனைத்தும் ☐

25) மஞ்சள் காமாலை வந்த பின் தாயின் கவனிப்பு முறைகள்?

அ) தாய்ப்பால் மட்டுமே கொடுத்தல் ☐

ஆ) சூரிய ஒளியில் குழந்தையை காண்பித்தல் ☐

இ) அடிக்கடி குழந்தையின் தோல், கால், மலம், சிறுநீரினை கண்காணித்தல் ☐

ஈ) மேற்கண்ட அனைத்தும் ☐

PLANNED TEACHING PROGRAMME ON MINOR DISORDERS OF NEW BORN

TOPIC	: Minor disorders of newborn
GROUP	: Post natal mothers in post natal wards
PLACE	: Post natal ward, IOG, Egmore, Chennai-08.
TIME	: Convenient time – 30 minutes
INSTRUCTOR	: Investigator
METHOD OF TEACHING	: Lecture cum Discussion.
TEACHING AIDS	: Flash chard, Broucher

GENERAL OBJECTIVES

At the end of the session, mothers will be able to acquire knowledge and attitude about minor disorders of newborn and to develop desirable skills and attitude to practice this in their day today life activities.

SPECIFIC OBJECTIVES

At the end of the class, postnatal mothers will be able to

- ♣ define the term newborn
- ♣ enlist out minor disorders of newborn
- ♣ specify about the causes and its management of vomiting in newborn
- ♣ explain about constipation in minor disorder of newborn
- ♣ brief about the causes and its management of diarrhoea in newborn
- ♣ describe about minor disorder of newborn regarding napkin rashes
- ♣ narrate the physiological jaundice in minor disorder of newborn

INTRODUCTION

Good morning. I am M.Sc Nursing II year, student of college of nursing, MMC, Chennai-3. I have come here to discuss about minor disorders of newborn and enrich the knowledge of the mothers towards taking care of the baby.

let us see one proverb i.e. “PREVENTION IS BETTER THAN CURE “ It means we should safeguard our newborn baby from any illness by following preventive measures. Similarly, we have to give importance to treat the minor disorders of newborn as early as possible in order to prevent the complication and to seek early hospitalization.

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
1.	2min	define the term newborn	. **DEFINITION OF TERM** **NEWBORN OR NEONATE** The period from birth to 28th days of life is called neonatal period & the infants in this period is termed as neonate or newborn baby. Early neonatal period refers to first 7 days or 168 hours of life. late neonatal period from 7 days to 28 completed days of life. -Parul Datta.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
2.	3min	enlist out minor disorders of newborn	**MEANING OF MINOR DISORDERS OF NEWBORN** Minor disorder or aliments are a physical condition in which there is a disturbance of normal functioning. **MINOR DISORDERS OF NEWBORN** **1. Vomiting** **2. Constipation** 3. **Diarrhoea** **4. Napkin Rash** **5. Physiological Jaundice**	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
3.	5min	specify about the causes and its managemen t of vomiting in newborn	**1.VOMITING** It occur in neonates due to various organic and non organic causes **Organic causes** **Mechanical**-Instestinal obstruction,meconiumplug etc., **Neurological**-Birth injury, congenital anomalies of CNS leads increases intracranial pressure. **Metabolic**-vomiting leads to hypoglycaemia, etc., **Infectious** causes- septicaemia, meningitis, encephalitis, gastroenteritis,etc. **Non organic causes** Irritation of the stomach due to swallowed amniotic fluid and blood, faculty feeding technique.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			MANAGEMENT **No management** requires in case of regurgitation. **Non organic causes** should be managed by Proper feeding technique, burping or holding the baby upright Made to sit up on the lap for 5 to 10 minutes after feeding along with reassurance & guidance to the mother. Slight head –up position to be maintained during feeding. Turning head to one side – to prevent aspiration of vomitus. General cleanliness & Hygienic measures to be maintained. After vomiting-neck folds, face, back of the ear to be cleaned. Mouth wash to be given. Stomach wash may be needed in persistent vomiting – to remove swallowed amniotic fluid & blood which is given with 100 ml normal saline.Prolonged vomiting –associated symptoms, like fever, projectile vomiting, bile stained etc.,	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
4.	5min	explain about constipation in minor disorder of newborn	**2.CONSTIPATION** Constipation referred to as bowel movements are like hard, little pellets, firm and difficult to pass **CAUSES** **Organic causes** Congenital abnormalities of GIT, hirschsprung's disease etc., need to be investigated. **Non organic causes** Inadequate breast feeds, Insufficient fluid intake by mother **Signs** Breastfed baby in the Ist weeks or Ist month of life not getting enough breast milk to eat either losing weight or will not be gaining weight not having enough full wet diapers	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Management Artifical fed baby, can be managed by additional glucose water, extra sugar in the milk, honey & orange juice. **No laxatives** should be used Lubricated stimulus of rectum often initiates reflex peristaltic activity. Breast fed baby, can be managed by advise to give more breast milk advice to breast fed exclusively advice to improve breast feeding not to initiate artificial fed **Seek medical help & call your pediatrician** Baby has delayed passage of meconium during first week of life and has problem in passing bowel movement to rule out organic cause such as hirshsprungs disease, cystic fibrosis etc.,	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
5.	5 min	brief about the causes and its management of diarrhoea in newborn	**3. DIARRHOEA** Breastfed baby passes 2 to 6 times golden yellow, sticky, semi-loose stools due to high content of lactose indicate breast feeding stool. In case of diarrhoea –Baby passes foul smelling liquid stool, loose, wet, watery, look ill, passes less urine & become inactive associated with fever or weight loss. **CAUSE** Intake of large quantities of glucose water or honey Unhygienic feeding practices includes Before each feeding not cleaning breast & aerola Overfeeding- mothers eat (>onion,tomatoes, cabbages, chilliesetc) Bottle feeding – un cleaned utensil's Serious underfeeding- not providing sufficient breast milk	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Serious neonatal diarrhoea occur in septicaemia, necrotising enterocolitis. photo therapy. Some babies make bowel movements with force & sound & some pass gas loudly many times in a day increasing mother's anxiety. But this is due to immaturity of the newborn's digestive system & is quite normal. **Signs of dehydration** Less than 6 wet diapers a day (24 hours) Dry mouth and lips, A lack of tears when baby is crying Poor feeding, A depressed soft spot on top of the baby's head Irritability **Seek medical help** Diarrhoea can be dangerous for newborns it lead to dehydration & weight loss, if your baby has diarrhoea without any other symptoms & it does not go away within 24 hours, notify the doctor.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			MANAGEMENT Diarrhoea is mild - you can often manage it yourself at home. Treat baby diarrhoea – to continue to breast fed more frequently, baby has loose stools needs extra fluids Breast milk contains – the fluids & nutrition your baby needs to replace what she's loosing diarrhoea & antibodies in your breast milk help your baby fight off infection & diseases. Soiled napkins – Can irritate baby's skin cause diaper rash so change wet & dirty napkin often, wash your hands after each diaper change to prevent spread of infection.. Antidiarrhoeal medicine can be harmful to babies, so it's not recommended. Hygienic measures to be improved. food hygiene (breast care) personal hygiene (clean baby buttocks & baby's cloth) environmental hygiene IV Fluid therapy Systemic antibiotics } needs hospitalized baby	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
6.	5min	describe about minor disorder of newborn regarding napkin rashes	**4.NAPKIN RASH** Napkin rash is a common form of inflamed skin (dermatitis) that appears as a patchwork of bright red skin on baby's bottom. Napkin rash commonly found in artificially fed babies also called as ammonia dermatitis. **Causes** lack of cleanliness due to after passage of urine or stool Prolonged wet nappies, Perianal skin may become red, indurated & excoriated **Due to** use of nylon or water tight plastic napkins. Perianal dermatitis often found in diarrhoea or fungal infection **Signs and Symptoms** Redness over the diaper area- around the genitals, buttocks and thighs. Increase discomfort, especially at napkin changing time. Tight, papery skin or skin that is shiny & bright red. In boys an inflamed penis	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			If rash occurs along with any of the following Fever Blister or boils A rash that extends beyonds the napkin area. Pus or weeping discharge. Unusual sleepiness **Management** The letters **ABCDE** are a useful way to remember all of these measures. A- air out the skin by allowing the baby to go napkin – free B- barrier, use a paste or ointment to protect the skin C- clean, keep the skin clean D- disposable diapers, during an episode of diaper rash, consider using disposable napkin. E- educate, educate yourself about how to prevent a recurrence of napkin rash	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Keeping the area dry & exposed to air or sunlight Application of coconut oil or Application bland ointment or antifungal cream. **PREVENTIVE MEASURES** Immediate changing of soiled napkins Napkins should be washed adequately with antiseptic lotion Drying the area, don't apply napkin too tightly, otherwise it may cause friction against the skin, which could make the rash worse. Let the baby go without her napkin as much as possible. Allow her skin to breathe, air to circulate and reduce friction and skin contact with irritants.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
7.	5min	narrate the physiologic al jaundice in minor disorder of newborn	**5. PHYSIOLOGICAL JAUNDICE** A yellow pigment called bilirubin is formed from the disintegrated red blood cells. These are excreted from blood by liver, but the liver in a new born baby is not mature enough at birth to perform this function, Therefore the bilirubin pigments in the blood are not excreted and its level rises resulting in yellowish discoloration of sclera and skin of newborn baby. This **yellowish discoloration** is Jaundice. Normally liver gets matured by 5th day & starts excreting the yellow pigments & jaundice in turn starts disappearing. Such jaundice is a normal phenomenon called **Physiological jaundice**. In term newborns physiological jaundice **appears** on 2 nd or 3 rd day & starts decreasing gradually from 5th day & **disappears** by 7th – 10th day.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Characteristics of physiological jaundice It appears in 30 to 72 hours of age in term babies & In preterm babies may appear earlier but not before 24 hours of age. Maximum intensity of jaundice is found on 4th day in term babies and 5th to 6th day in preterm babies. Serum bilirubin does not exceed 15mg/dl Usually disappears by 7th to 10th day in term babies & by 14 th day in preterm babies. **To examine jaundice** Stretch the skin between two fingers over bony surface like forehead, chin, middle of chest, shin of leg & sole of foot. This presses out the blood from the skin & yellow colour is seen more closely. Mild jaundice- visible over the face Severe jaundice- over the legs below the knee & sole.	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Management Subsides spontaneously & no treatment is needed Mother needs encouragement for exclusive breastfeeding for adequate hydration & reassurance. If you have a sleepy baby, express your colostrum and feed by paladai. or tickling behind the ears or on the soles keep the baby aroused during feeding. Learn your babys hunger cues and go with them Dont wait until your baby is crying to start to feed him. Ensure that you are feeding at least 8 to 12 times in a 24 hour period. Exposing the baby to sunlight for about 10 to 20 minutes. If necessary phototherapy can be given. While exposing the baby to sunlight, baby's eyes and genital should be covered. Careful observation for signs of complications along with essential neonatal care are important	Explaining	Flash card	Observing and listening

S.NO	TIME	SPECIFIC OBJECTIVES	CONTENT	RESEARCHER ACTIVITY	AV AIDS	MOTHERS ACTIVITY
			Need medical consultation Severe jaundice damages the babys brain & chances of recurrent fits occur is called **kernicterus.** **Jaundice –** become severe in case of Birth asphyxia, Infection in preterm babies, Rh incompatibility i.e mother is Rh-ve & baby is Rh+ve need exchange transfusion. **Seek medical aid or to call doctor** a. Baby with persisting jaundice for more than 14 days b. Baby passing dark coloured urine c. Baby passing pale or chalky white coloured stool	Explaining	Flash card	Observing and listening

CONCLUSION

So far, I explained the minor disorders of newborn and its causes, sign and symptoms, management and prevent measures. I think it was very much useful for primi postnatal mothers for the above mentioned information. These information will guide postnatal mothers to do prompt intervention and to prevent further complication so that early hospitalization will reduce mother's anxiety and mordibity rate.

திட்டமிட்ட போதனை திட்டத்தின் மூலமாக கற்பித்தல் நிகழ்வு

தலைப்பு	:	பச்சிளங் குழந்தையின் சிறு குறைபாட்டினை பற்றி குழந்தை பெற்றெடுத்த தாய்மார்களிடையே அறிவுத் திறனைப் பற்றிய ஆய்வு
குழு	:	குழந்தை பெற்றெடுத்த தாய்மார்கள்
இடம்	:	பேறுகால பின் கவனிப்பு பிரிவு, அரசு மகப்பேறு மருத்துவமனை, எழும்பூர், சென்னை-600 008.
நேரம்	:	30 நிமிடம்
கற்பிப்பவர்	:	செவிலியர் முதுகலை இரண்டாம் ஆண்டு மாணவி
கற்பிக்கும் முறை	:	திட்டமிட்ட கற்பித்தலின் மூலம் விவரித்தல் மற்றும் அறிவுதிறனை மேம்படுத்துதல்
கருவிகள்	:	மின்னட்டை, துண்டுப்பிரசுரம்

நோக்கம்

பச்சிளங் குழந்தையின் சிறு குறைபாட்டினை சிகிச்சை மற்றும் தடுப்பு முறையின் விரிவான விளக்கத்தின் மூலம் தாய்மார்களின் அறிவுத்திறனையும், செயல் திறனையும் மேம்படுத்துதல்.

துணை நோக்கம்

வகுப்பு முடிவில் தாய்மார்கள் அறியவேண்டியவை

- பச்சிளங்குழந்தையின் சிறு குறைபாடுகளை பட்டியலிடுக
- வாந்தியெடுத்தல் பற்றிய விவரங்களைக் குறிப்பிடுக
- மலச்சிக்கலைப் பற்றிய விவரங்களைக் குறிப்பிடவும்
- வயிற்றுப்போக்கு பற்றிய சிகிச்சை மற்றும் தடுப்பு முறைகளை குறிப்பிடுக
- நாப்கின் பயன்படுத்துவதால் ஏற்படும் விளைவுகளை பற்றி விவரித்தல்
- உடலியல் மஞ்சள் காமாலைகளைப் பற்றிய விளக்கங்கள்

முன்னுரை

அனைவருக்கும் வணக்கம். என் பெயர் சேஷமாலினி நான் சென்னை மருத்துவமனையில் உள்ள செவிலியர் கல்லூரியில் இரண்டாம் ஆண்டு முதுகலை செவிலிய பட்ட மேற்படிப்பு படித்துக் கொண்டிருக்கிறேன். தமிழ்நாடு டாக்டர் எம்.ஜி.ஆர் மருத்துவ பல்கலைக்கழக விதிமுறையின் படி தங்களிடம் பச்சிளங்குழந்தையின் சிறு குறைபாட்டின் சிகிச்சை மற்றும் தடுப்பு முறைகளைப் பற்றியும் அக்குழந்தைகளின் தாய்மார்களுக்கு விரிவாக எடுத்துக் கூற உள்ளேன்.

பொதுவாக பச்சிளங் குழந்தைகளை தாக்கக்கூடிய வாந்தி, வயிற்றுப்போக்கு, மலச்சிக்கல், நாப்கின் புண், உடலியல் மஞ்சள் காமாலை இவற்றைப் பற்றி பார்க்கலாம்.

நாம் அனைவருக்கும் தெரிந்த பழமொழி ‘‘வரும் முன் காப்போம்’’ அதாவது நோய் வருவதற்க்கு முன் குழந்தைகளை நோயிலிருந்து பாதுகாக்க வேண்டும். பச்சிளங் குழந்தையின் சிறு குறைபாட்டின் சிகிச்சை மற்றும் தடுப்பு முறைகளை புரிந்து கொள்வதின் மூலம் பிறந்த குழந்தையை நோயிலிருந்து எப்படி பாதுகாக்க முடியும் என்பன போன்றவற்றை நாம் பார்ப்போம்.

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
1.	5 நிமி	வாந்தி எடுத்தல் பற்றி விரிவான விளக்கங்கள்	பிறந்த நாள் முதல் 28வதுந ாட்கள் வரை குழந்தை பிறந்த காலமாகவும், இந்த காலகட்டத்தில் குழந்தகளை புதிதாக பிறந்த அல்லது பச்சிளங் குழந்தை என்றும் அழைப்பார்கள். **வாந்தி** தாய்ப்பால் குடித்த பின்னர் குழந்தை பாலினை கக்குவதை வாந்தி என்று அழைக்கிறோம். ஆரோக்கியமான கைக்குழந்தைகள் ஏப்பம் விடும்போது சில சமயங்களில் சிறிதளவு பால் வெளியே வருவது இயற்கையே. **காரணம்** தவறான பால் கொடுக்கும் முறைகளினால் குழந்தைக்கு வயிற்றில் எரிச்சல் ஏற்படுத்தி வாந்தி வர காரணமாக அமைகின்றன. **தடுப்பு முறை** குழந்தைக்கு பாலூட்டிய பின்னர் குழந்தையைத் தோளில் சாய்த்துக் கொண்டு லேசாக முதுகில் தட்டவும். இது குழந்தை பால் குடிக்கும்போது பாலுடன் சேர்த்து உட்கொண்ட காற்று வெளியே வர உதவுகிறது. பாலூட்டிய பின்	விவரித்தல்	பிரதிபளிப்பு அட்டை கொண்டு விவரித்தல்	கவனித்தல்

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			குழந்தையைக் கீழே கிடத்தும் போது குழந்தை வாந்தி எடுத்தால், ஒவ்வொரு முறையும் பாலூட்டிய பின்னர் குழந்தையைக் கொஞ்ச நேரம் நிமிர்த்தி வைத்திருக்கவும். குழந்தைக்கு பாலூட்டிய பின்னர் குழந்தையைத் தாயின் மடியில் அமர்த்தி 5 முதல் 10 நிமிடங்கள் மடியில் குழந்தையை உட்கார வைக்க வேண்டும். ஒரு பக்கத்திற்கு தலையை திருப்புதல் வாந்தியின் போது புரை ஏறுதலை தடுக்க உதவுகிறது. பொது தூய்மை நடவடிக்கைகள் பராமரிக்கப்பட வேண்டும். வாந்தி எடுத்த பிறகு கழுத்து மடிப்புகள், முகம், வாய் போன்ற பகுதிகளை மீண்டும் சுத்தம் செய்ய வேண்டும்.			
2.	5 நிமி	மலச் சிக்கலை பற்றிய விரிவான விளக்கங்கள்	**2. மலச்சிக்கல்** மலச்சிக்கல் என்பது குழந்தைகள் கடினமான, காய்ந்து மற்றும் சிரமப்பட்டு மலம் கழியும். **காரணம்** 1. குறிப்பாக செயற்கை முறையில் தயாரிக்கப்பட்ட பால் உணவு உட்கொள்வதன் மூலம் ஏற்படுகிறது.	விவரித்தல்	பிரதிபளிப்பு அட்டை கொண்டு விவரித்தல்	கவனித்தல்

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			2. தாய் பாலினை போதுமான அளவு கொடுக்கவில்லை என்றாலும் மலச்சிக்கல் ஏற்படலாம். 3. குடல் அடைப்பு மற்றும் நோய் தாக்கம் போன்றவைகள் மூலமும் மலச்சிக்கல் ஏற்படலாம். **அறிகுறிகள்** தாய்ப்பால் அருந்தும் குழந்தைகள் முதல் வாரங்கள் அல்லது முதல் மாதங்களில் போதுமானளவு தாய்பாலினை கொடுக்கவில்லை என்றால். குழந்தைக்கு எடை குறைவு அல்லது எடை அதிகரிப்பு இரண்டுமே பெற இயலாது. போதுமான அளவு சிறுநீர் கழிக்க இயலாது. **சிகிச்சை முறைகள்** 1. தாய்ப்பால் குடிக்கும் குழந்தைக்கு சிகிச்சை அளிக்கலாம்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			2. புட்டிப்பால் குடிக்கும் குழந்தைகளுக்கு சிகிச்சை அளிக்கலாம் 3. தாய்ப்பால் கொடுப்பதன் மூலம் மலச்சிக்கலை தவிர்க்கலாம், குழந்தையின் மூளை வளர்ச்சிக்கும் தாய்ப்பால் உதவுகிறது மற்றும் நோய் எதிர்ப்பு சக்தியை அளிக்கிறது. தாய்ப்பாலினை அடிக்கடி அதிக அளவு குழந்தைக்கு கொடுக்கவேண்டும். குழந்தை தூங்கும் பொழுது தாய்மார்கள் குழந்தையை விழிக்க வைத்து தாய்பாலினை அடிக்கடி கொடுக்க வேண்டும். ஹிஸ்ஃப்ரங் நோய், சிஸ்டிக் ஃபைப்ரோஸிஸ் முதலியவை போன்ற கரிம காரணங்களினாலும் மலச்சிக்கல் ஏற்படலாம்.			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
3.	10 நிமி	வயிற்றுப் போக்கு பற்றிய சிகிச்சை மற்றும் தடுப்பு முறைகளை விரிவாக விளக்குதல்	**3. வயிற்றுப்போக்கு** தளர்வான தண்ணீரால் மலம் வெளியேறுதல் அல்லது துர்நாற்றத்துடன் பச்சை நிறத்தில் தண்ணீர் போல் மலம் வெளியேறும். தாய்ப்பால் குடிக்கும் குழந்தைகள் லாக்டோசின் அதிக அளவு இருப்பதால் மலம் 2 முதல் 6 முறை நிறத்தில் மஞ்சள் ஒட்டும் தன்மை உள்ளதாகவும் இருக்கும். **காரணம்** வயிற்றுப்போக்கு குளுகோஸ் நீர் அல்லது சர்க்கரை தண்ணீர் அல்லது அதிக அளவு தேன் உட்கொள்வதினால் ஏற்படுகிறது. வைரஸ்கள் மற்றும் பாக்டீரியாக்கள் வயிற்றுப் போக்கின் கடுமையான தொற்று காரணமாக இருக்கக்கூடும். தாய்மார்கள் தங்கள் உணவின் ஒவ்வாமை (சாக்லேட், காரமான உணவுகள், காபின் (Caffeine) காரணமாக தாய்பாலின் மூலம் பச்சிளங் குழந்தைக்கு வயிற்றுப் போக்கு ஏற்படக் கூடும்.	விவரித்தல்	பிரதிபளிப்பு அட்டை கொண்டு விவரித்தல்	கவனித்தல்

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி-யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			அறிகுறிகள் 1. வயிற்றுப்போக்கு ஒரு நாளைக்கு 10 தடவைக்கு மேல் இருக்கும். 2. சிறிதளவு சிறுநீர் கழிக்கிறதா? அல்லது 6 மணி நேரத்திற்கு மஏற்பட்டும் சிறுநீர் கழிக்காமல் இருக்கிறதா என கவனிக்கவும். 3. குழந்தை நன்றாக விழித்து இருக்கிறதா அல்லது மிகுந்த தூக்கநிலையாக உள்ளதா என்று கவனிக்கவும். 4. அழும் போது கண்ணீர் உள்ளதா, இல்லையா என்று கவனிக்கவும். 5. கண்கள் சாதாரணமாக அல்லது குழி விழுந்து இருக்கின்றதா			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			6. வாயும், நாக்கும் ஈரமாக அல்லது காய்ந்து இருக்கின்றதா 7. தோலை கிள்ளிவிடும் போது சாதாரண நிலைக்கு உடனே வருகிறதா அல்லது மிக மெதுவாக பழைய் நிலைக்கு வருகிறதா என்று கவனிக்கவும். 8. தலையில் உச்சிப்பொட்டு சாதாரணமாக அல்லது மிகவும் குழி விழுந்து இருக்கிறதா என்று கவனிக்கவும். **தடுப்பு முறைகள்** பச்சிளங் குழந்தைகளுக்கு நீரிழப்பு மிக விரைவாக ஏற்பட்டுவிடுகிறது. இது மிகவும் ஆபத்தானது. தாய்ப்பால் குடிக்கும் குழந்தைக்கு 6 மாதம் வரை தண்ணீர் தேவையில்லை. கண்டிப்பாக தாய்ப்பால் மட்டும் கொடுக்கவேண்டும். கைக்குழந்தைக்கு குறிப்பாக கோடை காலத்தில் தண்ணீர் அதிகம் தேவைப்படுகிறது. எனவே குழந்தைக்கு			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			அடிக்கடி தாய்ப்பால் கொடுக்க வேண்டும். தாய்ப்பாலில் தண்ணீர் மற்றும் ஊட்டச்சத்து அதிகமாக இருப்பதால் வயிற்றுப் போக்கின் பொழுது நீரிழப்பை தடுக்கின்றது மற்றும் தாய்ப்பாலில் நோய் எதிர்ப்பு சக்தி (ஆன்டிபயாட்டிக்) இருப்பதால் தொற்றுநோயை வராமல் தடுக்கின்றது. குழந்தைகள் மலம் கழித்த பிறகு அந்த பகுதியினை வெதுவெதுப்பான வெந்நீரால் சுத்தம் செய்து உலர வைக்க வேண்டும் மற்றும் கைகளை நன்றாக சுத்தம் செய்யவேண்டும் மற்றும் தாய்ப்பால் கொடுக்கும் முன் மார்பக பகுதியினை வெதுவெதுப்பான வெந்நீரால் ஒவ்வொறு முறையும் சுத்தம் செய்த பிறகு குழந்தைக்கு தாய்ப்பால் கொடுக்க வேண்டும். **மருத்துவ உதவி** கடுமையான வயிற்றுப்போக்கு குறிப்பாக வாந்தியுடன் சேர்ந்து நீரிழப்பு ஏற்படுவது மிகவும் ஆபத்தானது. உடனடியாக மருத்துவமனைக்கு கொண்டு சென்று சிரைவழி திரவங்கள் மூலமாக சிகிச்சை செய்ய வேண்டும்.			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
4.	10 நிமி	நாப்கின் பயன் படுத்துவதால் ஏற்படும் விளைவு–களை பற்றி விரிவான விளக்கம்	**4. நாப்கின் ராஷ் (உள்ளாடைகளினால் ஏற்படும் தோல் தடித்தல்)** நாப்கின் புண் என்பது நீர் உறிஞ்சும் பஞ்சு அல்லது துணையினை (நாப்கின்) அடிக்கடி மாற்றாமல் அதிக நேரம் சிறுநீர் மற்றும் மலம் படுவதால் அதிலுள்ள பாக்டீரியாக்கள் மற்றும் கிருமிகளால் ஏற்படும் ஒருவகை புண்ணாகும். நாப்கின் புண் பொதுவாக தோலின் மீது சிவந்த நிறத்தில் குழந்தையின் இடுப்பின் பின்புறம் காணப்படும். **காரணங்கள்** 1. அதிக நேரத்திற்கு மலம் மற்றும் சிறுநீரால் ஏற்படும் அரிப்பு 2. குழந்தைகளுக்கு புதுவகை உணவுகளை ஆரம்பித்தல் 3. புதுவகையான நாப்கின்களால் ஏற்படும் அரிப்பு 4. பாக்டீரியா மற்றும் பூஞ்சைகளினால் ஏற்படும் தொற்றுகள்	விவரித்தல்	பிரதிபளிப்பு அட்டை கொண்டு விவரித்தல்	கவனித்தல்

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			5. குழந்தையின் தோலின் தன்மையினால், மற்ற தோல் நோயினால பொதுவாக நாப்கின் புண் ஏற்படுகிறது. 6. நாப்கினால் ஏற்படும் உராய்வு 7. நோய் எதிர்ப்பு சக்தி மருந்துகளை குழந்தைகளுக்கு கொடுக்கும் போது அடிக்கடி மலம் கழிக்க நேரிடுவதாலும் ஏற்படும். 8. அதிக நேரம் ஒரே நாப்கினை பயன்படுத்தும் போது ஏற்படுகிறது. **நாப்கின் புண்ணால் ஏற்படும் அறிகுறிகள்** சிவப்பு நிறமாக தோல் மாறுதல் தோலில் சிறிய கட்டிகள் தோன்றுதல் தோல் பிளந்து வெளியே தெரிதல்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			புண் ஆறாமல் தொடர்ந்து இருக்கும் அதுமட்டுமல்லாமல் பின்வரும் அறிகுறிகள் தோன்றும் காய்ச்சல், கொப்புளம், சிவப்பு நிறம் நாப்கின் அணியும் இடத்திற்கு அருகாமையில் பரவும், சீழ் வடிதல் மற்றும் தூக்கமின்மை. **நாப்கின் புண்ணின் சிகிச்சை முறைகள்** பொதுவாக நாப்கின் புண்ணிற்கு பலவிதமான முறையில் சிகிச்சைகளை மேற்கொள்ள வேண்டும். அப்போதுதான் முழுமையாக நாப்கின் புண்ணை குணப்படுத்த முடியும். பின்வரும் முறைகளை கடைப்பிடிப்பதினால் நாப்கின் புண்னை குணப்படுத்த முடியும். 1. காற்றோட்டமாக வைத்திருத்தல் 2. பாதுகாப்பாக நோய் தொற்றில்லாமல் வைத்திருத்தல் 3. சுத்தமாக வைத்திருத்தல்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			4. ஒரு முறை மட்டுமே பயன்படுத்தும் நாப்கினை மறுமுறை பயன்படுத்தாமல் இருப்பது. குழந்தைகளுக்கு நாப்கின் புண் ஏற்படும் போது முடிந்தவரை அடிக்கடி நாப்கினை பயன்படுத்தாமல் காற்றோட்டமாக வைத்திருக்க வேண்டும். **நாப்கின் புண்னை தடுக்கும் முறை** 1. குழந்தையின் உடம்பை சுத்தமாகவும், ஈரமாகவும் பார்த்துக் கொள்ள வேண்டும். 2. நாப்கினை மறுபடியும் அணிவதற்கு முன்பு நன்றாக உடம்பை உலர்த்த வேண்டும் 3. நன்றாக சுத்தப்படுத்தி, உலர்த்தி பாதுகாக்கப்பட்ட பின்னர் சரியான முறையில் நாப்கினை அணிவித்தல் வேண்டும். அதனை மிகுந்த இறுக்கமாகவோ அல்லது தோலில்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			உராயும் படியாகவோ இல்லாமல் பார்த்துக் கொள்ள வேண்டும். 4. நாப்கின் ஈரமில்லாமல் பார்த்துக் கொள்ள வேண்டும். ஒரு வேளை ஈரமாக இருந்தால் உடனடியாக நாப்கினை மாற்றவேண்டும். எல்லாவற்றையும் விட நாப்கினை பயன்படுத்தாமல் இருப்தே நாப்கின் புண்ணை தடுக்கும் மிகச்சிறந்த வழியாகும்.			
5.	10 நிமி	உடலியல் மஞ்சள் காமாலை பற்றிய விரிவான விளக்கங்கள்	**உடலியல் மஞ்சள் காமாலை** உடலியல் மஞ்சள் காமாலை என்பது பச்சிளங் குழந்தையின் மீது மஞ்சள் நிறத்திலான நிறமாற்றம் உடல் முழுவதும் காணப்படுவது. **குழந்தைக்கு எப்பொழுது மஞ்சள் காமாலை ஏற்படும்** மஞ்சள் காமாலை குழந்தை பிறந்தவுடன் நிறைமாத குழந்தையாக இருந்தால் நான்காவது நாளில் மஞ்சள் காமாலை ஏற்படுகிறது. குறை மாத குழந்தையாக இருந்தால்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி-யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			ஐந்தாவது மற்றும் ஆறாவது நாளில் மஞ்சள் காமாலை ஏற்படுகிறது. **சிகிச்சை முறைகள்** தன்னியல்பாக உட்கொள்ளல் மற்றும் சிகிச்சை தேவைப்படாது. 1. அடிக்கடி தாய்ப்பால் கொடுக்குமாறு உறவினர்கள் தாயை ஊக்குவிக்க வேண்டும். 2. பச்சிளம் குழந்தைக்கு உடலில் மஞ்சள் காமாலை இருந்தால் குழந்தையை தினமும் விடியற்காலையில் சூரிய ஒளி படும் படி 10 முதல் 20 நிமிடம் காண்பிக்க வேண்டும். 3. குழந்தைக்கு தேவைப்பட்டால் வெப்ப சிகிச்சை (போட்டோ தெரபி) கொடுக்கப்படலாம் 4. குழந்தைக்கு சூரிய ஒளி வெளிப்படுத்துகையில்			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி-யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			குழந்தையின் கண்கள் மற்றும் பிறப்புறுப்புகளை மூடி வைக்க வேண்டும். 5. ஏதேனும் சிக்கல்களின் அறிகுறிகள் இருந்தால் கவனமாக கவனிக்க வேண்டும் மற்றும் பிறந்த நாள் முதல் 28 நாட்களுக்கு தீவிர பராமரிப்பு மிகவும் அவசியமானது. **மருத்துவரின் ஆலோசனையை அணுகவும்** 1. தொடர்ந்து மஞ்சள் காமாலை 14 நாட்களுக்கு மேல் நீடித்தல் 2. சிறுநீர் கழிக்கும் போது மிகவும் அடர்ந்த மஞ்சள் நிறத்தில் இருத்தல் 3. மலம் கழிக்கும் போது வெளிர் அல்லது சாக்லேட் வெள்ளை நிறத்தில் இருத்தல்.			

வ. எண்	நேரம்	குறிக்கோள்	பொருளடக்கம்	ஆராய்ச்சி–யாளரின் செயல்	ஒலி, ஒளி சார்ந்த ஊடகங்கள்	கற்றுக் கொள்பவரின் செயல்
			மருத்துவ உதவியை நாடுங்கள் குழந்தை பிறந்த நேரம் முதல் இருபத்தி நான்கு மணி (24 Hours) நேரத்திற்குள் மலம் (மெக்கோனியம்) கழிக்கவில்லை என்றால் உடனடியாக மருத்துவரை அணுகவும். குழந்தை பிறந்த நேரம் முதல் நாற்பத்தி எட்டு மணி நேரம் (48 Hours) வரை சிறுநீர் கழிக்கவில்லை என்றால் உடனடியாக மருத்துவரை அணுகவும்.			

முடிவுரை

இதுவரை நாம் பச்சிளங் குழந்தையின் சிறு குறைபாட்டினை பற்றியும் அதன் பல்வேறு வகைகள் மற்றும் அதற்கான காரணங்களை பார்த்தோம். குழந்தைகள் நமக்கு இன்றியமையாத சொத்தாகும். அவர்களை நல்ல முறையில் பேணிக்காப்பதே நமது தலையாய கடமையாகும்.

நன்றி.

INFORMATION TO PARTICIPANTS

Investigator : P. Seshamalini

Name of Participant:

Tittle: A study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward ,Institute of Obstetrics and Gynecology, government hospital for women and children at Egmore, Chennai-08.

This study is conducted in Institute of Obstetrics and Gynecology, Egmore, Chennai-8. You are invited to take part in this study. The information in this document is meant to help you decide whether or not to take part. Please feel free to ask if you have queries or concerns.

What is the Purpose of the Research (explain briefly)

This Research is conducted to evaluate the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers. We have obtained permission from the Institutional Ethical Committee.

The Study Design

Pre experimental pre test and post test.

Study Procedures

The study involves to evaluate the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward.

Possible Effects to You – No risks involved

Possible benefits to you

After finishing this study, investigator will provide information that about prevention and management of selected minor disorders of newborn

Possible benefits to other people

The result of the research may motivate the nurses to do prevention and management of selected minor disorders of newborn among primipara mothers.

Confidentiality of the information obtained from you

You have the right to confidentiality regarding the privacy of your medical information (personal details, results of physical examinations, investigations, and your medical history). The information from this study, if published in scientific journals or presented at scientific meetings, will not reveal your identity.

How will your decision not to participate in the study affect you?

Your decisions not to participate in this research study will not affect your daily living activities, medical care or you relationship with investigator or the institution. Your doctor will still take care of you and you will not lose any benefits to which you are entitled.

Can you decide to stop participating in the study once you start?

The participation in this research is purely voluntary and you have the right to withdraw from this study at any time during course of the study without giving any reasons.

However, it is advisable that you talk to the research team prior to stopping the treatment.

Signature of the Investigator

Signature of the mother with date

INFORMED CONSENT FORM

Title of the study: **"**A study to assess the effectiveness of planned teaching programme on knowledge of minor disorders of newborn among postnatal mothers admitted in postnatal ward, Institute of Obstetrics and Gynecology, government hospital for women and children at Egmore, Chennai-08".

Name of the Participant:

I ----------have read the information in this form (or it has been read to me). I was free to ask questions and they have been answered. As I hereby give my consent to include me as the participant in this study.

1. I have read and understood the consent form and the information provided to me.
2. I have had the consent document explained to me.
3. I have been explained about the nature of the study
4. I have been explained about my rights and responsibilities by the investigator
5. I am aware of the fact that I can opt out of the study at any time without having to give any reason and this will not affect my further treatment in the hospital.
6. I hereby give permission to the investigator to release the information obtained on my study to other team personnel, sponsors, Institution Ethics Committee and any person or agency required by law like Health Controller General of India, IEC. I understand that they are publicly presented.
7. I understand my identity will be kept confidential when the study is publicly presented.
8. I have had my questions answered to my satisfaction
9. I have decided to participate in the study.

I am aware that if I have any questions during this study, I should contact the investigator. By signing this consent form I attest that the information given in this document about the research on me has been clearly explained to me and understood by me. I will be given a copy of this consent document.

Signature /thumb impression of the participant with date

Signature of the investigator

Date ----------

ஆராய்ச்சி தகவல் தாள்

ஆராய்ச்சி தலைப்பு : குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை பற்றிய ஆய்வு.

ஆய்வாளர் பெயர் : பு.சேஷமாலினி

பங்கேற்பாளர் பெயர் :

தேதி :

வயது :

- ❖ ஆய்வாளர் மேற்கொள்ளும் ஆராய்ச்சியில் பங்கேற்க யாருடைய கட்டாயமுமின்றி முழுமனதுடன் சம்மதிக்கலாம். இதில் பங்கேற்பதன் நோக்கம்.
- ❖ இந்த ஆராய்ச்சியில் தகவல்களை தெரிந்து கொள்வதற்காகவும், அதனை பயன்படுத்துவதற்காக மட்டும் தான்.
- ❖ இந்த ஆராய்ச்சியின் நோக்கம் குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை பற்றிய ஆய்வு.

★ ஆராய்ச்சி மேற்க்கொள்ளும் முறை

இந்த ஆராய்ச்சியில் குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை கற்பித்தல் திட்டத்தின் மூலம் குறித்த ஆய்வு.

★ இதனால் ஆய்வாளருக்கான பயன்

இந்த ஆய்விற்க்கு பின் குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை பற்றிய ஆய்வுக்கு பின் உத்தியை கற்றுதந்ததன் தாக்கத்தினை அறியலாம்.

★ இதனால் பங்கேற்பாளருக்கான பயன்

- ❋ இந்த ஆய்விற்க்குப் பின் குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை பற்றிய ஆய்வுக்கு பின் அறிவு திறன் அதிகரிக்கிறது.
- ❋ ஆராய்ச்சியில் பங்கேற்கவில்லை என்றாலும், உங்களின் சராசரி வாழ்க்கைமுறையில் எந்தவித மாற்றமும் ஏற்படாது என்பதை தெரிவிக்கிறேன்.
- ❋ இந்த ஆராய்ச்சியில் பங்கேற்க விருப்பம் இல்லை என்றால் உங்களின் முழுமனதுடன் நீங்கள் இந்த ஆராய்ச்சியில் இருந்து விலகி கொள்ளலாம் என்பதை தெரிவிக்கிறேன்.
- ❋ இந்த ஆராய்ச்சியில் உங்களின் தகவல்களை பாதுகாப்பாக வைத்துகொள்கிறேன் என்பதை தெரிவிக்கிறேன்.
- ❋ இந்த ஆராய்ச்சியின் தகவல்களை வெளியிடும்போது, உங்களை பற்றிய அடையாளங்கள் வெளிவராது என்பதை உறுதி கூறுகிறேன்.

ஆய்வாளர் கையொப்பம் பங்கேற்பாளர் கையொப்பம்

தேதி தேதி

சுய ஒப்புதல் படிவம்

ஆராய்ச்சி தலைப்பு: குழந்தை பெற்றெடுத்த தாய்மார்களிடையே பச்சிளங்குழந்தையின் சிறு பிரச்சனைகள் பற்றிய அறிவு திறனை பற்றிய ஆய்வு.

ஆய்வாளர் பெயர் : பு. சேஷமாலினி.

பங்கேற்பாளர் பெயர் :

தேதி :

வயது :

- ❖ ஆய்வாளர் மேற்கொள்ளும் ஆராய்ச்சியில் பங்கேற்க யாருடைய கட்டாயமுமின்றி முழுமனதுடனும் சுயநினைவுடனும் சம்மதிக்கிறேன்.
- ❖ ஆய்வாளர் மேற்கொள்ள போகும் பரிசோதனைகளை மிக தெளிவாக விளக்கிக்கூறினார்.
- ❖ எனக்கு விருப்பமில்லாத பட்சத்தில் ஆராய்ச்சியிலிருந்து எந்நேரமும் விலகலாம் என்பதையும் ஆய்வாளர் மூலம் அறிந்து கொண்டேன்.
- ❖ இந்த ஆராய்ச்சி ஒப்புதல் கடிதத்தில் உள்ள விவரங்களை நன்கு புரிந்து கொண்டேன். எனது உரிமைகள் மற்றும் கடமைகள் ஆராய்ச்சியாளர் மூலம் விளக்கப்பட்டது.
- ❖ நான் ஆராய்ச்சியாளருடன் ஒத்துழைக்க சம்மதிக்கிறேன். எனக்கு ஏதேனும் உடல்நலக்குறைவு ஏற்பட்டால் ஆராய்ச்சியாளரிடம் தெரிவிப்பேன்.
- ❖ நான் வேறு எந்த ஆராய்ச்சியிலும் தற்சமயம் இடம்பெறவில்லை என்பதை தெரிவித்துக்கொள்கிறேன்.
- ❖ இந்த ஆராய்ச்சியின் தகவல்களை வெளியிட சம்மதிக்கிறேன். அப்படி வெளியிடும்போது என் அடையாளம் வெளிவராது என்பதை அறிவேன்.
- ❖ எனக்கு இந்த ஒப்புதல் கடிதத்தின் நகல் கொடுக்கப்பட்டது.

ஆய்வாளர் கையொப்பம் பங்கேற்பாளர் கையொப்பம்

தேதி தேதி

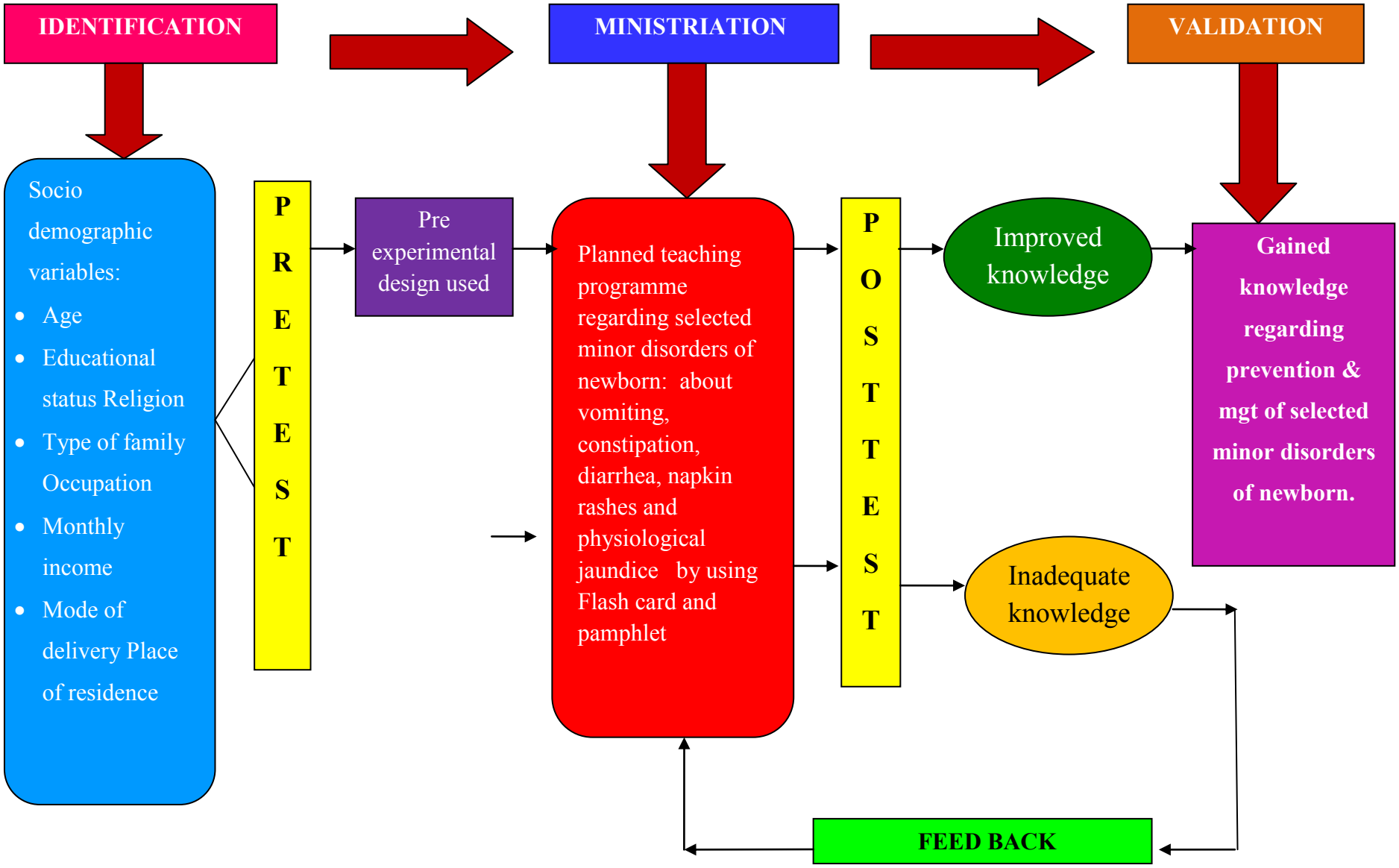


FIGURE 2.1: CONCEPTUAL FRAME WORK BASED ON WIEDENBACH HELPING ART THEORY

FIGURE 3.1SCHEMATIC REPRESENTATION OF RESEARCH METHODOLOGY

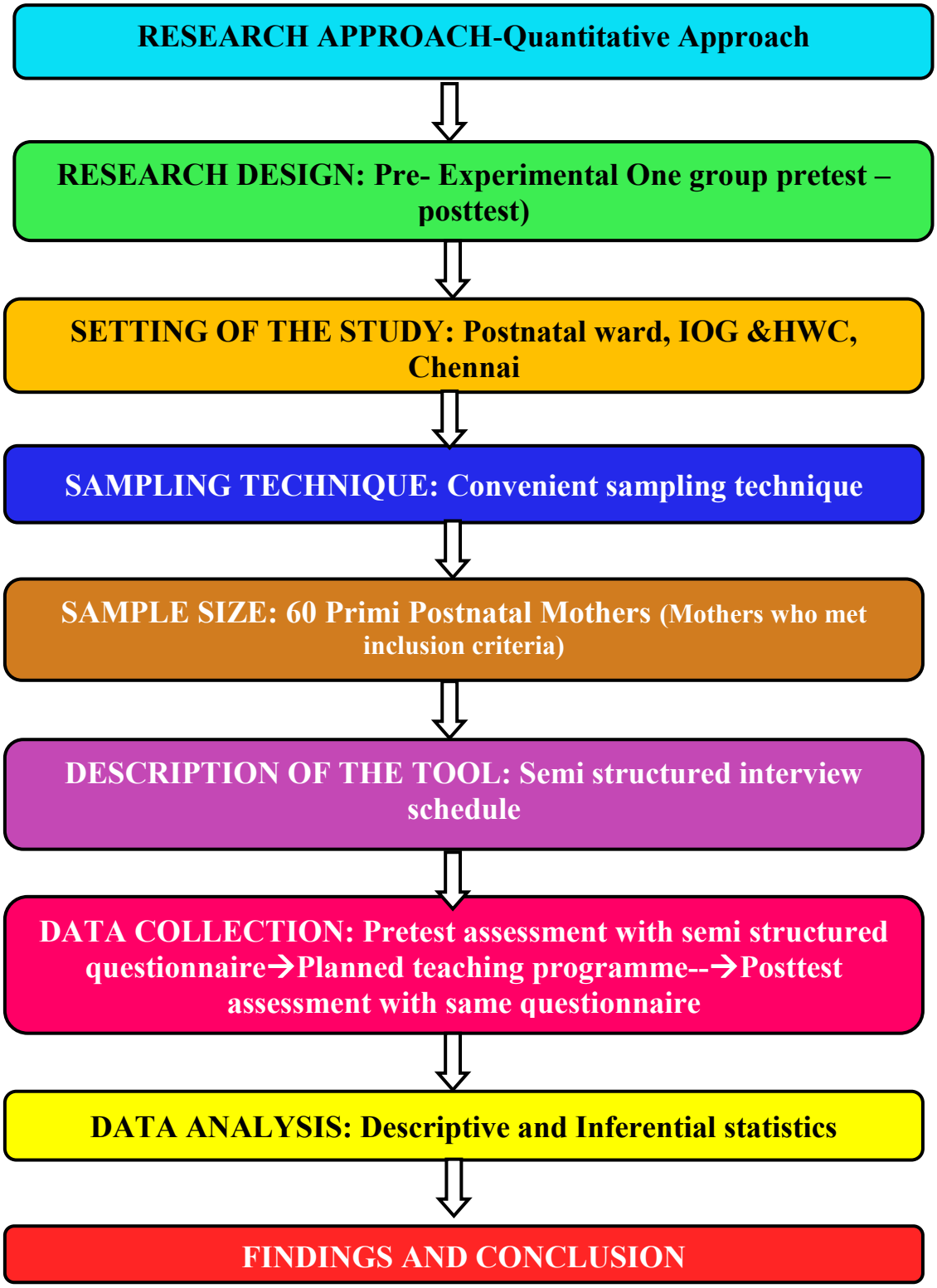
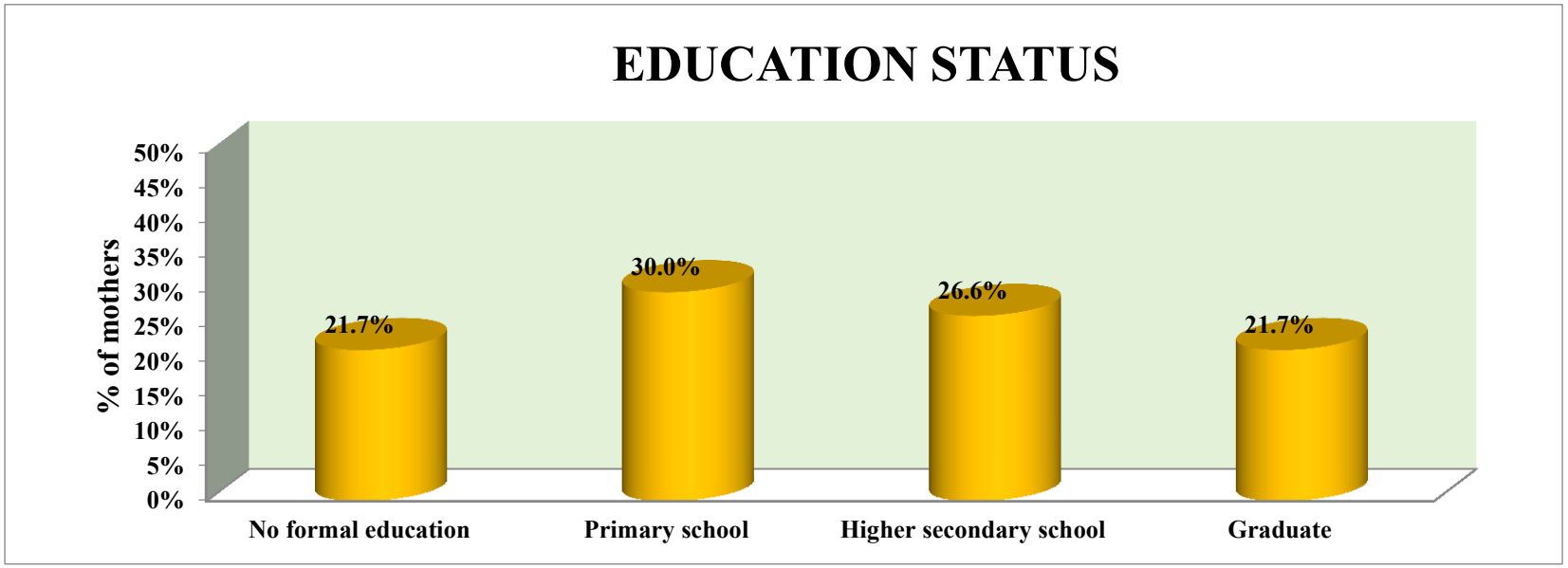
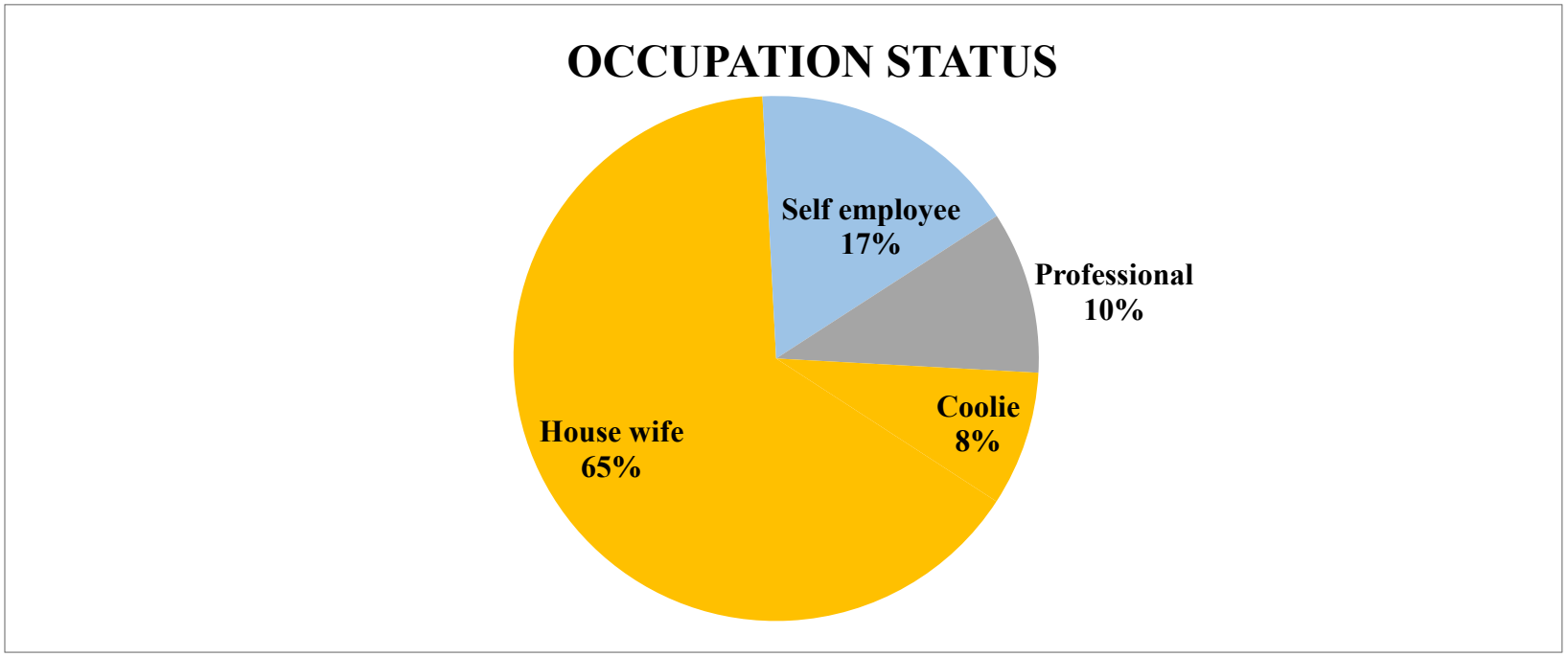


Fig4.1 Percentage distribution of education status of study participants of postnatal mothers



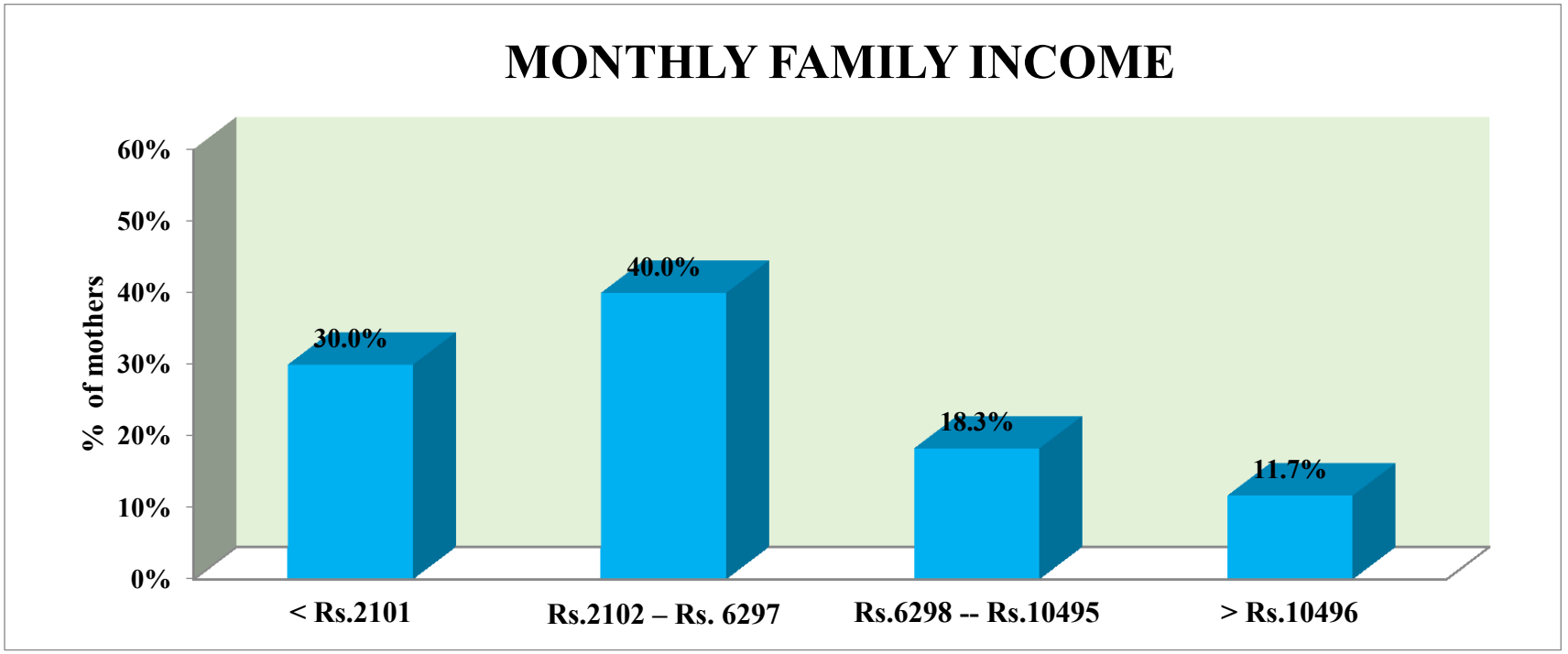
Regarding 21.7% mothers were not having formal education, 30.0% mothers were having primary school education, 26.6% mothers completed higher secondary school education, 21.7% mothers were Graduated.

Fig4.2 Percentage distribution of occupation status of study participants postnatal mothers



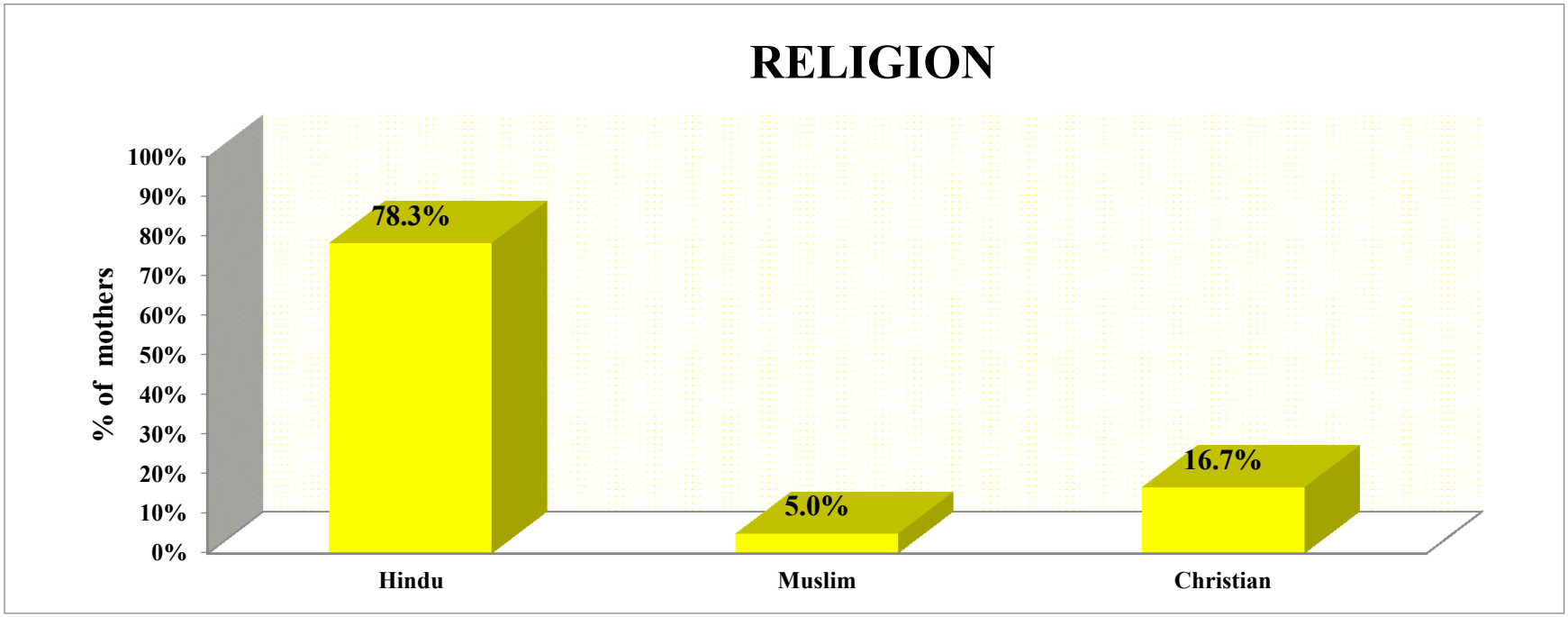
Regarding 65.0% mothers were house wife, 16.7% mothers were worked as self employee, 10.0% mothers were worked as a Professionals, 8.3% mothers were worked as Coolie.

Fig4.3 Percentage distribution of monthly family income of study participants of postnatal mothers



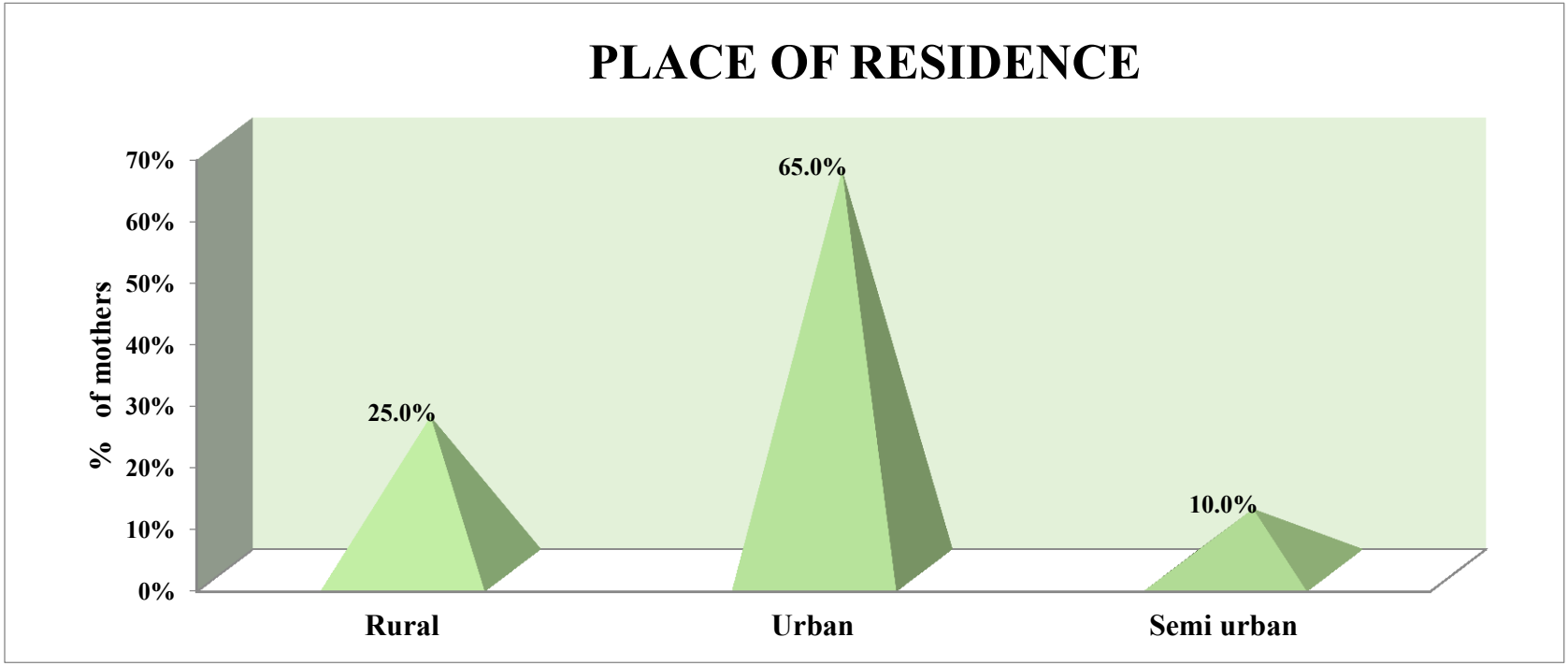
Regarding 30.0% mothers were belongs to income of < Rs.2101,and 40.0% mothers were belongs to income of Rs. 2102- Rs. 6297 and 18.3% mothers were belongs to income of Rs.6298-Rs.10495 and also 11.7% mothers were belongs to income of > Rs. 10496.

Fig4.4 Percentage distribution of religion of study participants of postnatal mothers



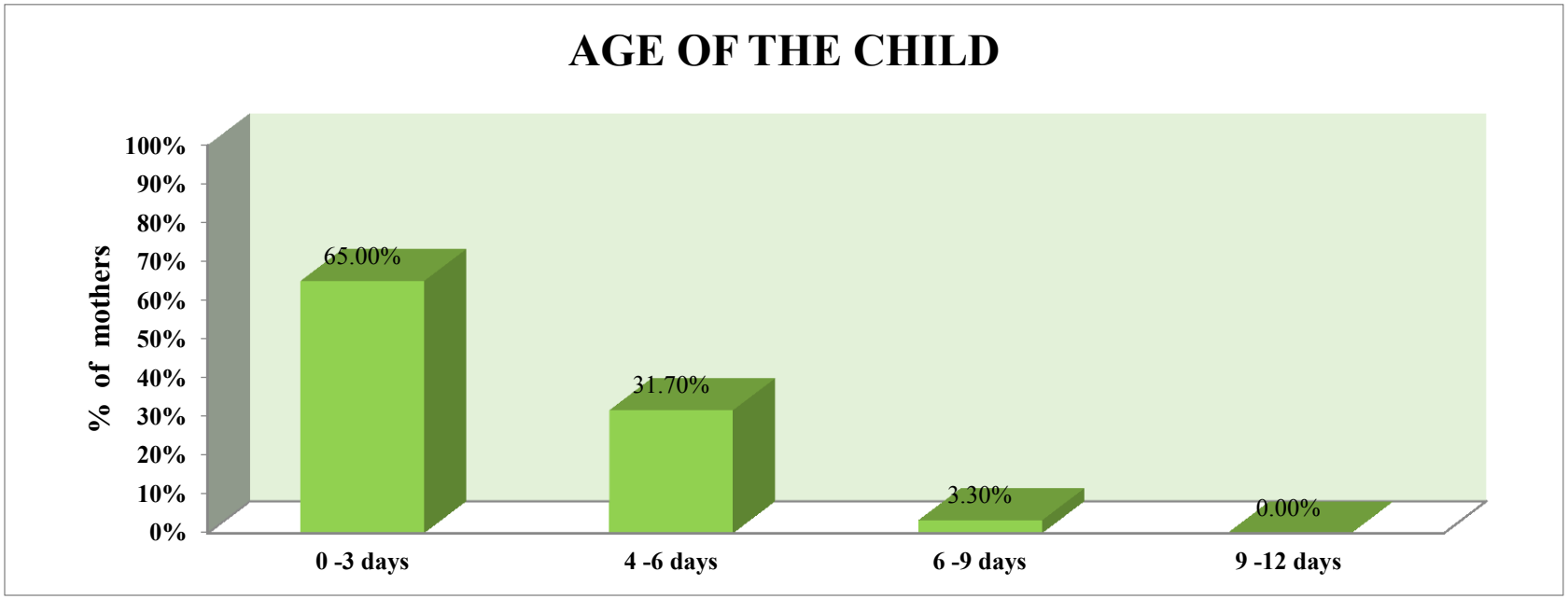
Regarding 78.3% mothers were belongs to Hindu religion and 5.0% mothers were belongs to Muslim religion and then 16.7% mothers were belongs to Christian religion

Fig4.5 Percentage distribution of place of residence of study participants of postnatal mothers



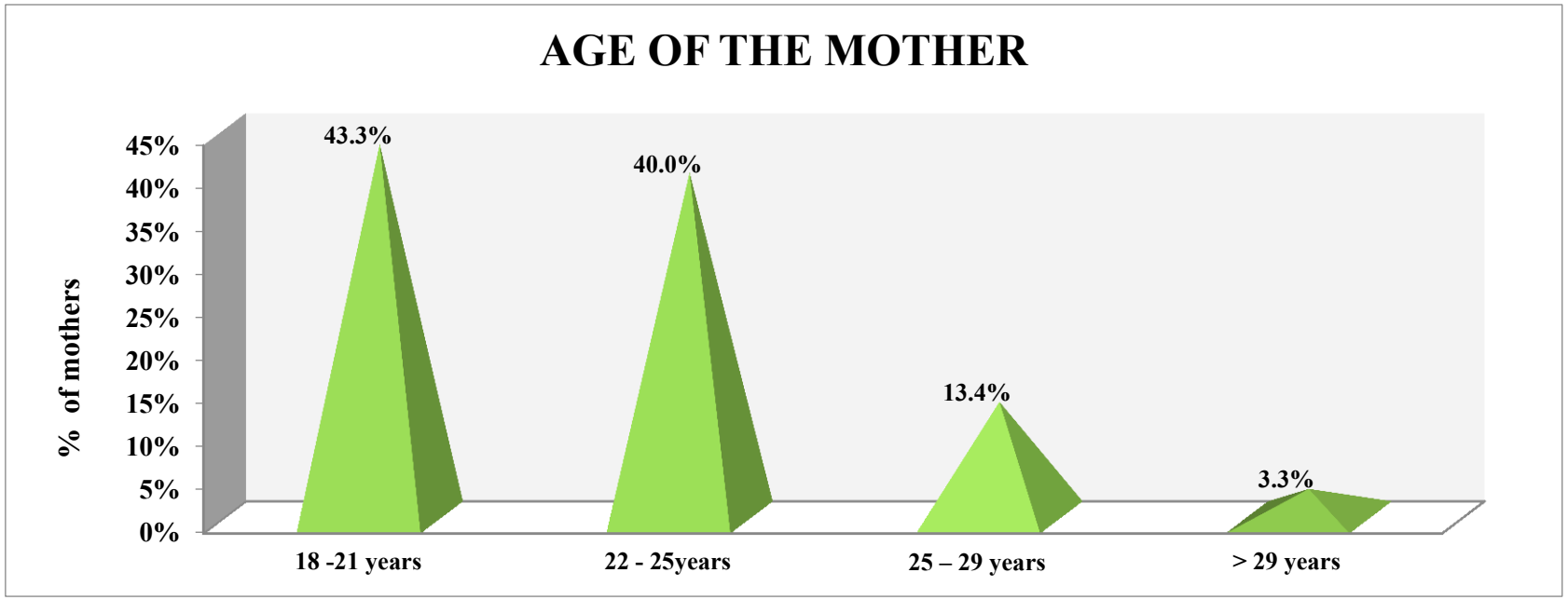
Regarding 25.0% were belongs to Rural area, 65.0% were belongs to Urban area and 10.0% were belongs to Semi Urban.

Fig4.6 Percentage distribution of age of the child of study participants of postnatal mothers



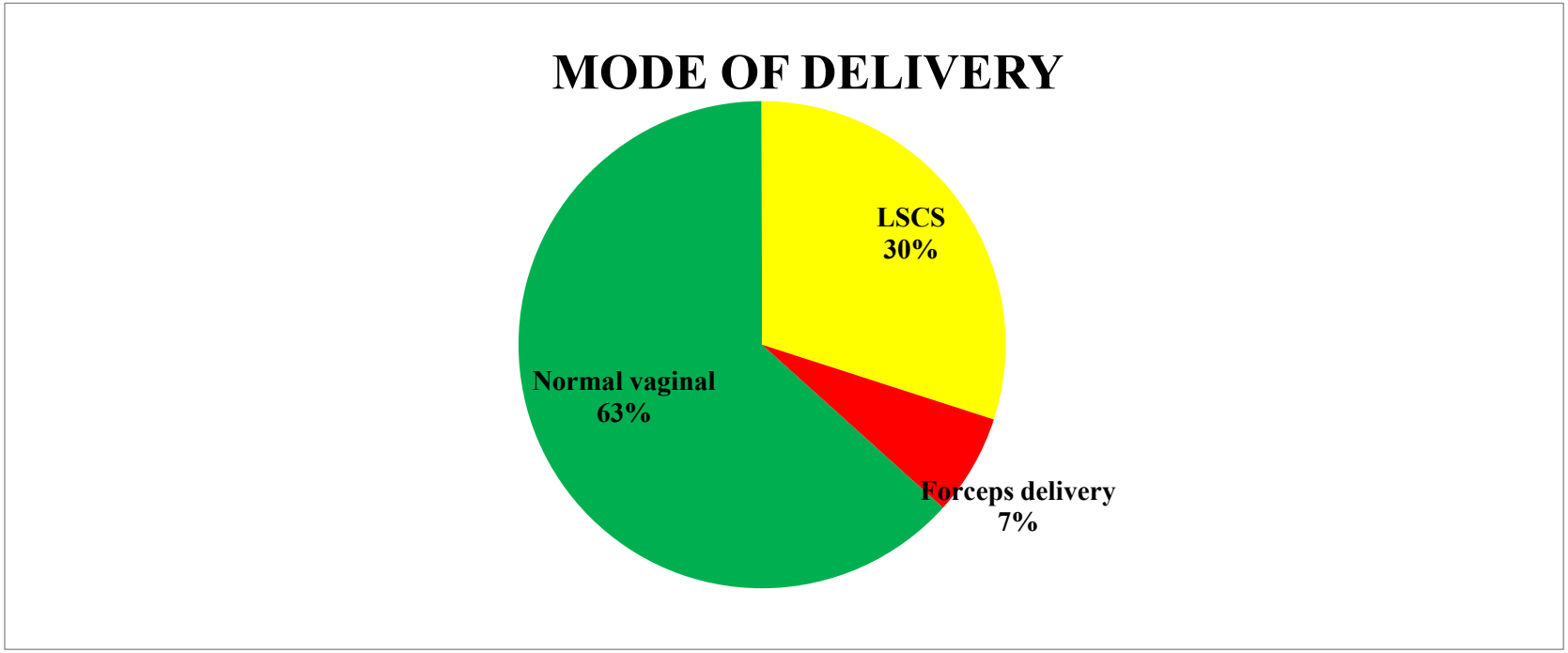
Regarding 65.0% child's were belongs to 0-3 days and 31.7% child's were belongs to 4 – days and also 3.3% child's were belongs to 6- 9 days

Fig4.7 Percentage distribution of age of the mother of study participants of postnatal mothers



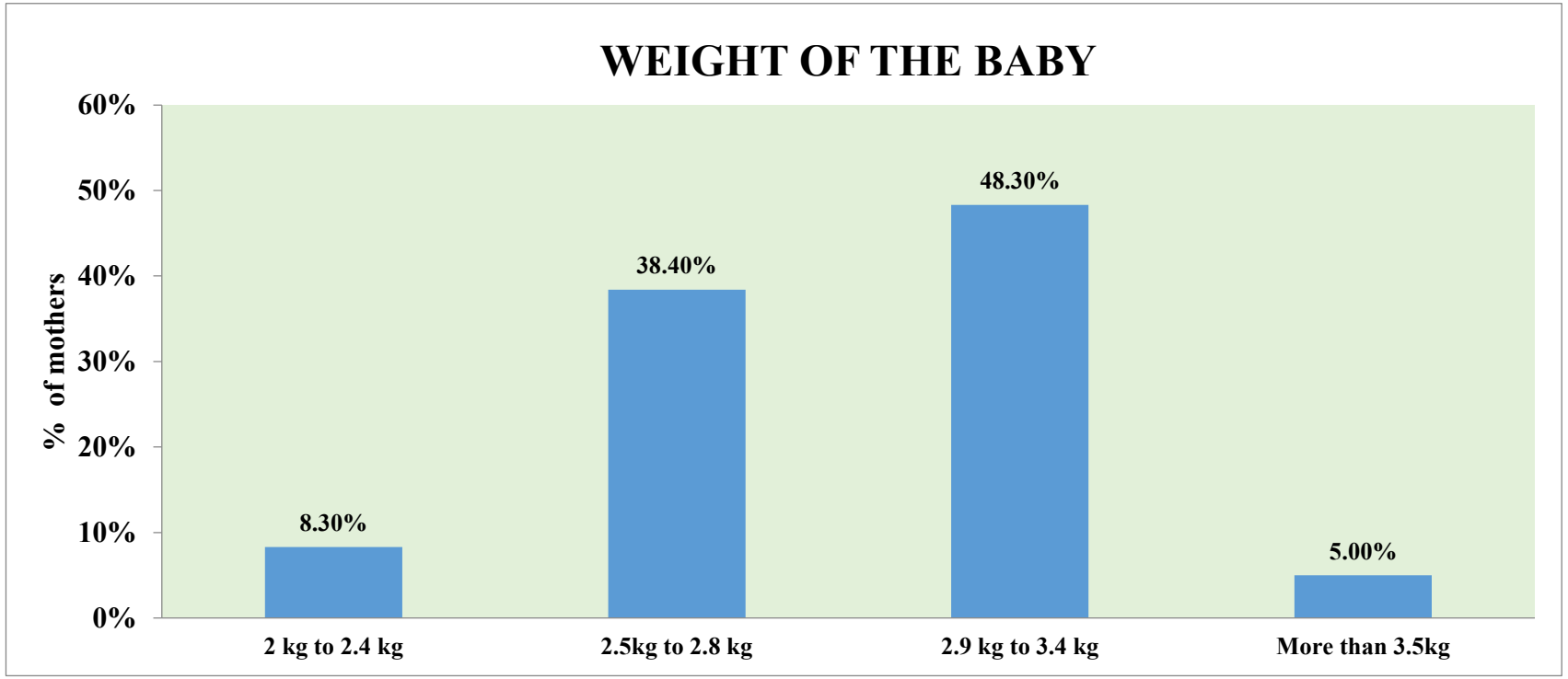
Regarding 43.3% mothers were belongs to age group of 18 – 21 years , 40.0% mothers were belongs to age group of 22 – 25 years ,13.4% mothers were belongs to age group of 25 – 29 years, 3.3% mothers were belongs to age group of > 29 years.

Fig4.8 Percentage distribution of mode of delivery of study participants of postnatal mothers



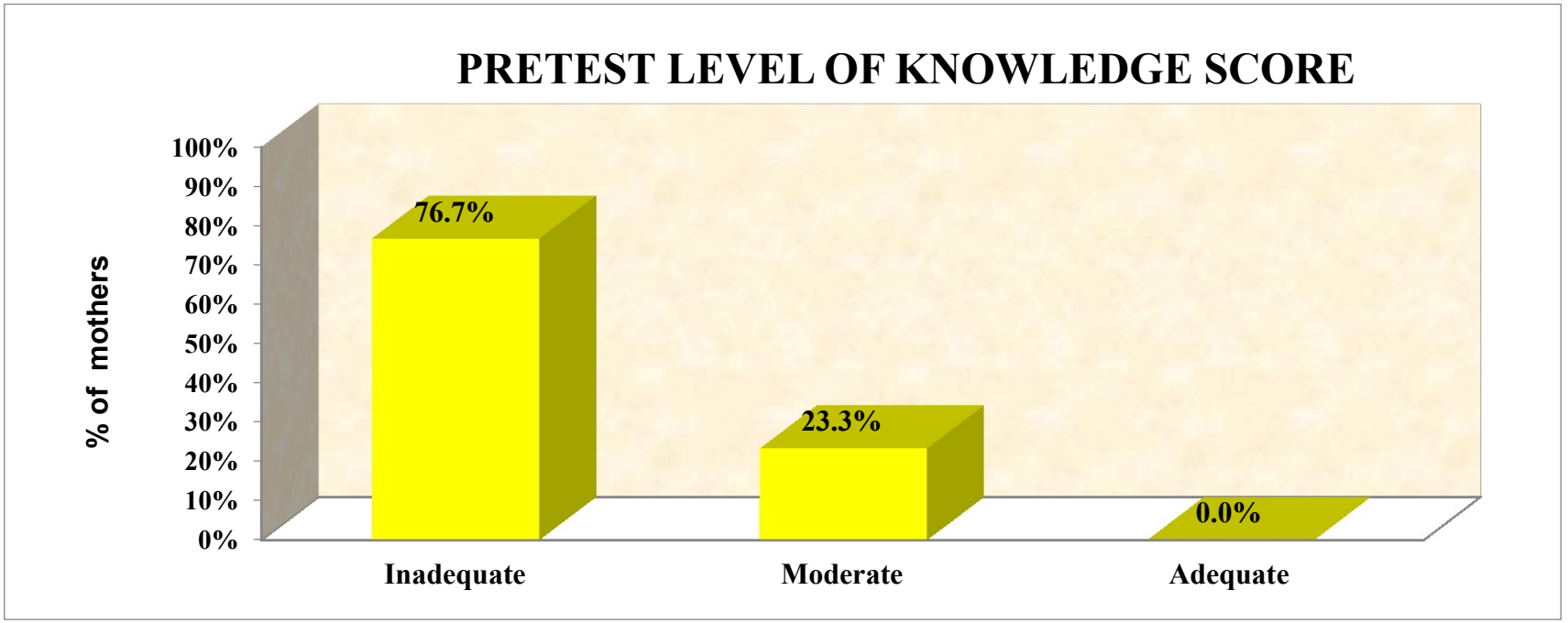
Regarding 63.3% mothers had normal vaginal delivery, 30.0% mothers had LSCS, 6.7% mothers had forceps delivery

Fig 4.9 Percentage distribution of weight of the baby of study participants of postnatal mothers



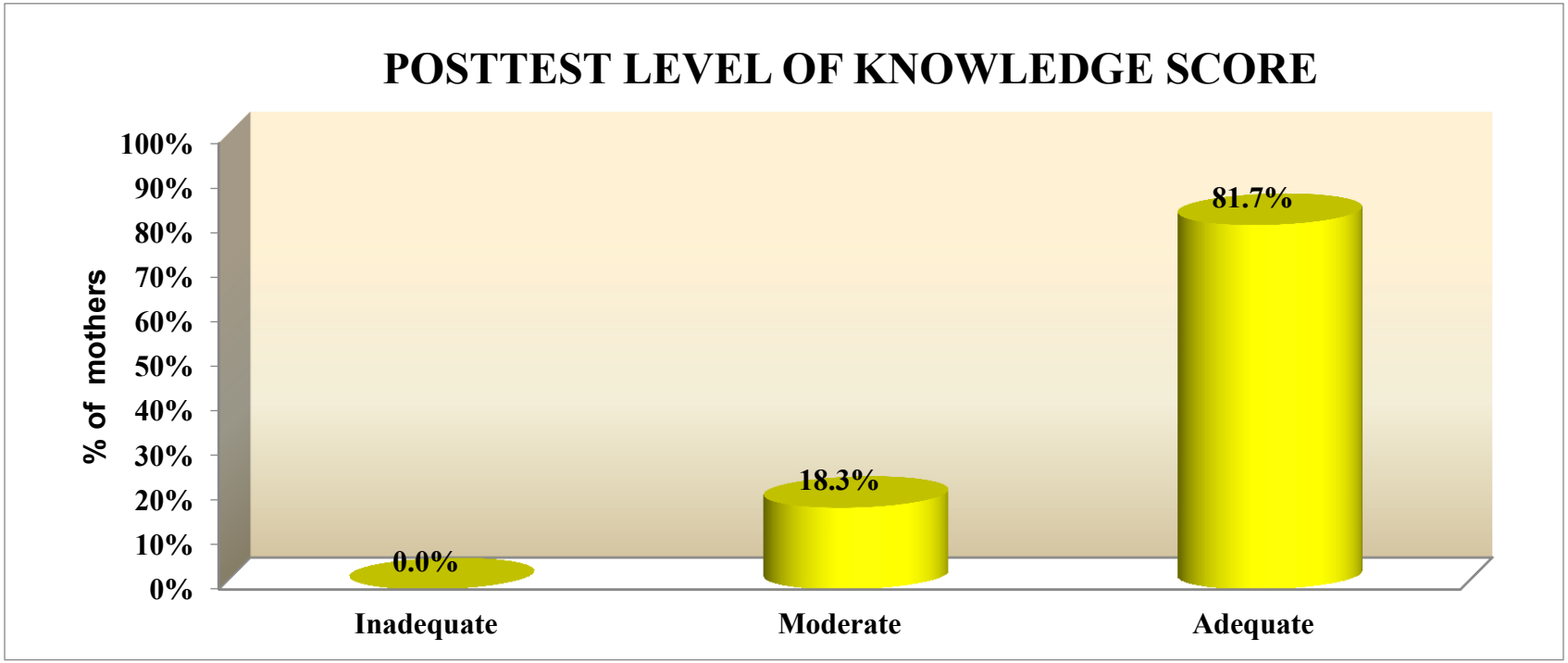
Regarding 8.3% baby's birth weight belongs to 2kg to 2.4 kg, 38.4% baby's birth weight belongs to 2.5 kg to 2.8 kg, 48.3% baby's birth weight belongs to 2.9 kg to 3.4 kg, more than weight belongs to 2kg to 2.4 kg

Fig4.10 Percentage distribution of pretest level of knowledge score on Minor disorders of newborn



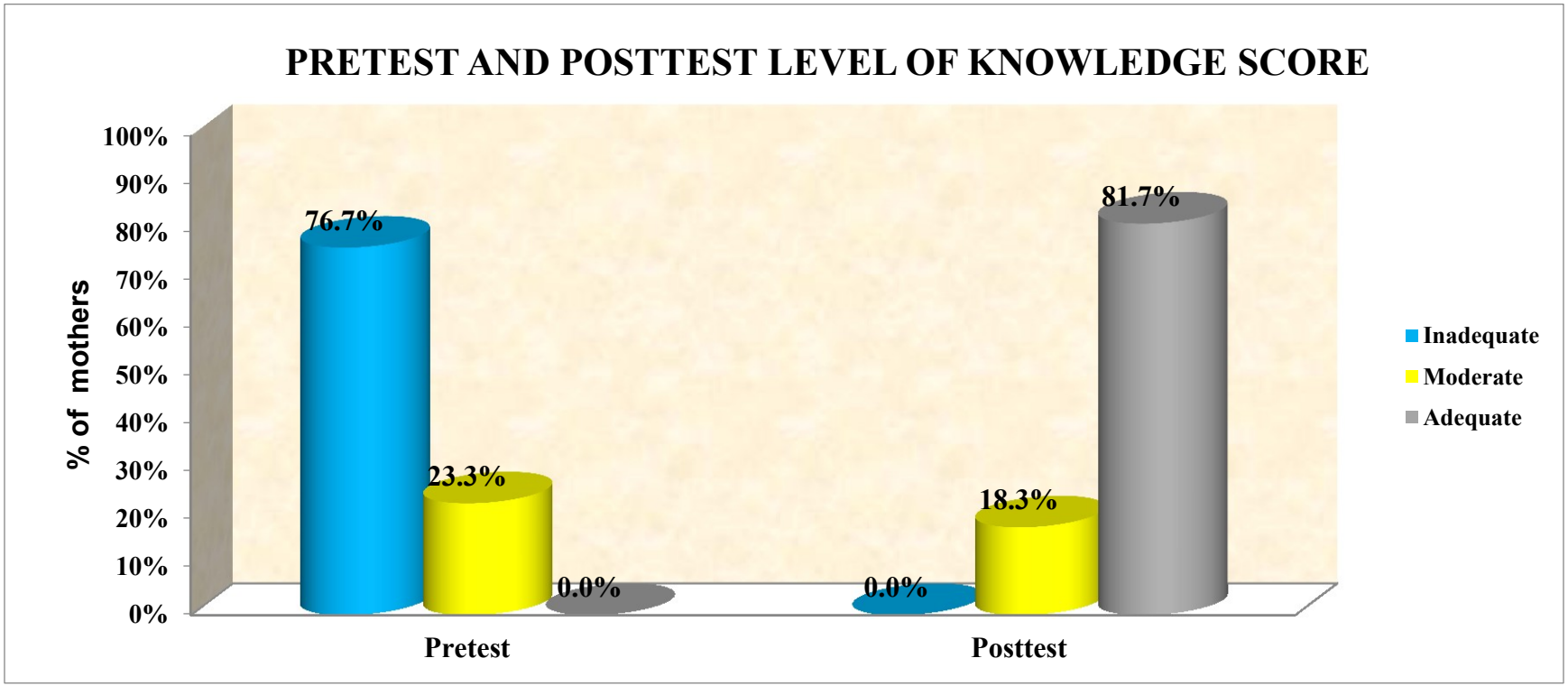
Regarding 76.7 % postnatal mothers were having inadequate knowledge, 23.3 % postnatal mothers were having moderate knowledge, and none of the postnatal mothers were not having adequate knowledge

Fig4.11 Percentage distribution of posttest level of knowledge score on Minor disorders of newborn



Regarding none of the postnatal mothers had inadequate knowledge, 18.3 % postnatal mothers had moderate knowledge, 81.7 % postnatal mothers were having adequate knowledge

Fig 4.15 Percentage distribution of pretest and posttest level of knowledge score on Minor disorders of newborn



Postnatal mothers had **inadequate knowledge** of 76.7 % in the pretest and none of the mothers had inadequate knowledge in the post test, postnatal mothers had **moderate knowledge** of 23.3 % in the pretest and 18.3 % in the post test, none of the postnatal mothers had **adequate knowledge** in the pretest and 81.7 % had adequate knowledge in the post test

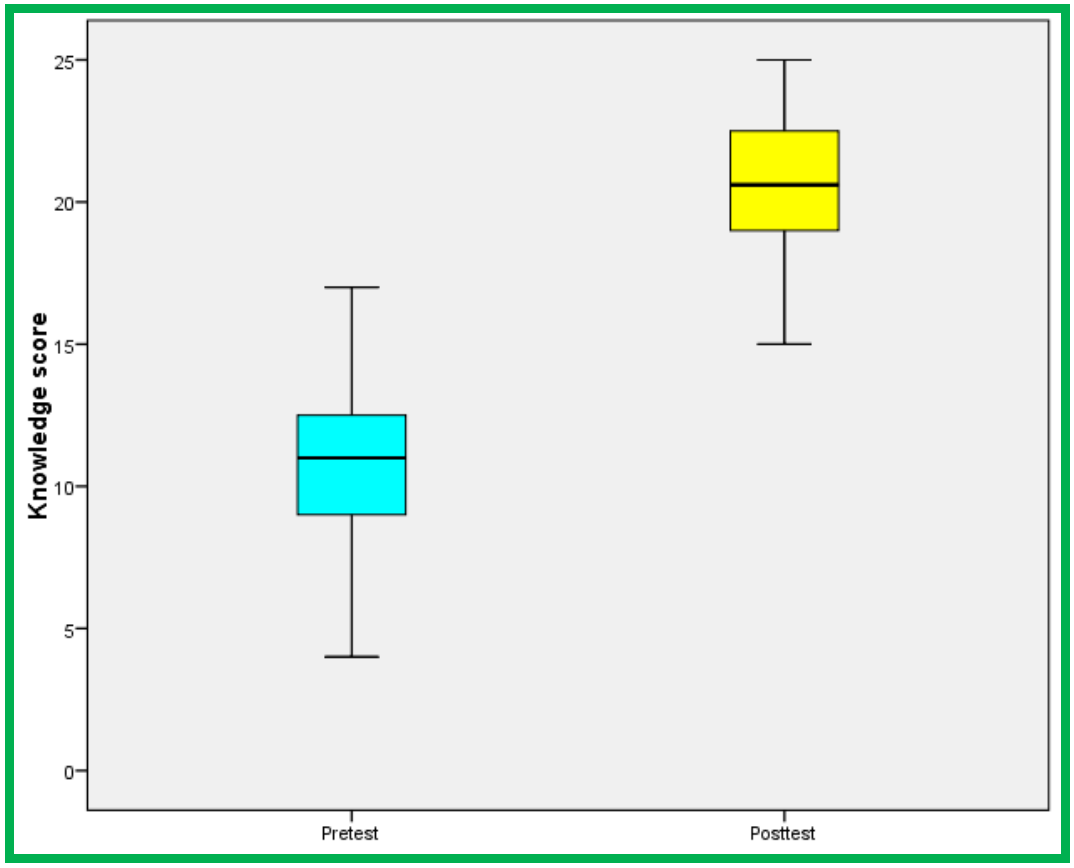
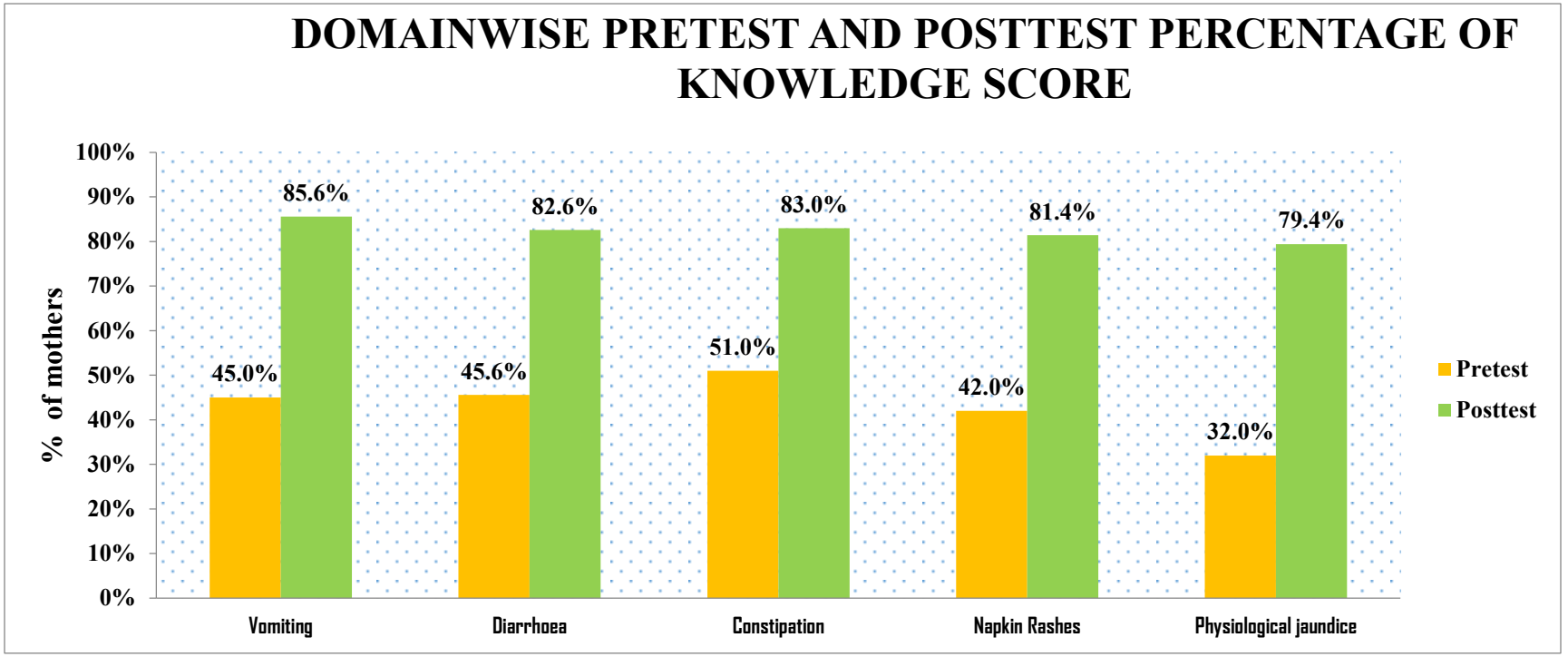


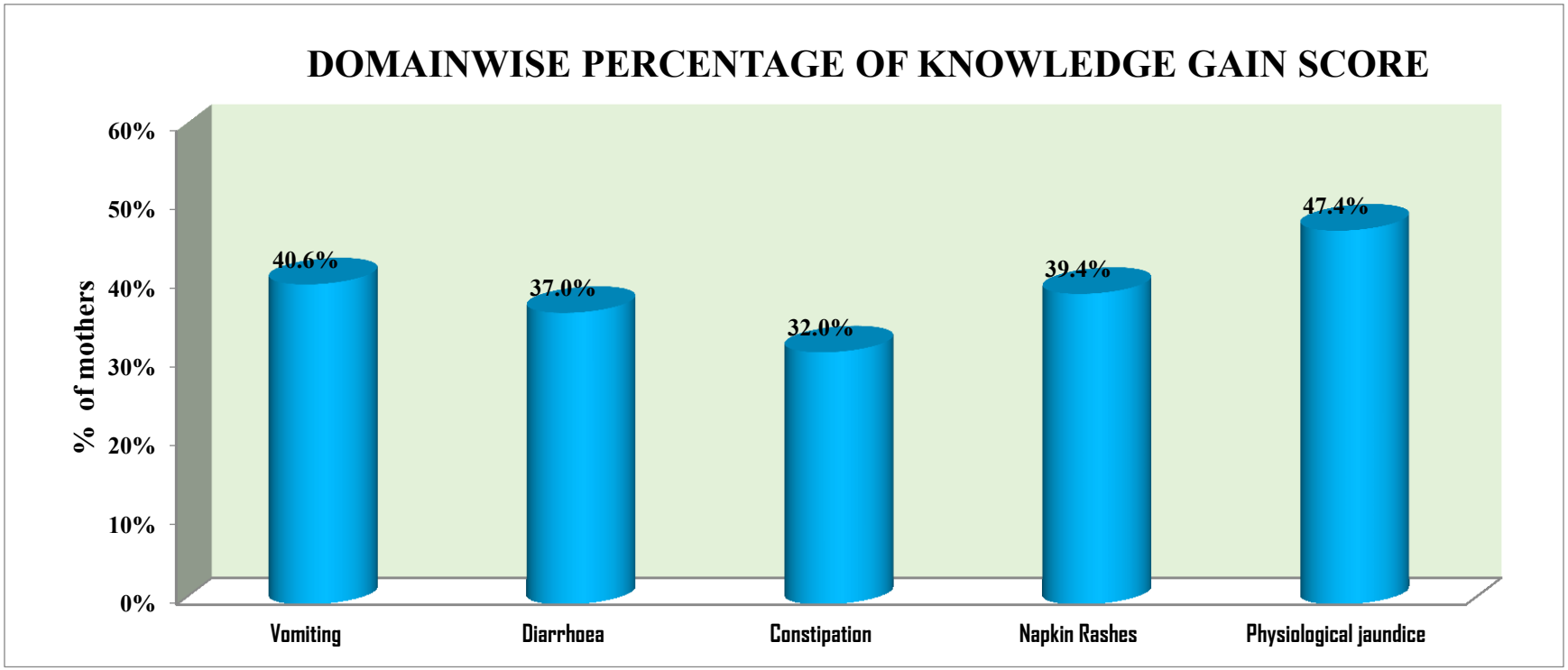
Fig 4.12: Box Plot Compares the pretest and posttest knowledge score of minor disorders of newborn among postnatal mothers admitted in postnatal ward at Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children at Egmore in Chennai.

Fig 4.13 Percentage distribution of domain wise pretest and post test level of knowledge score on Minor disorders of newborn



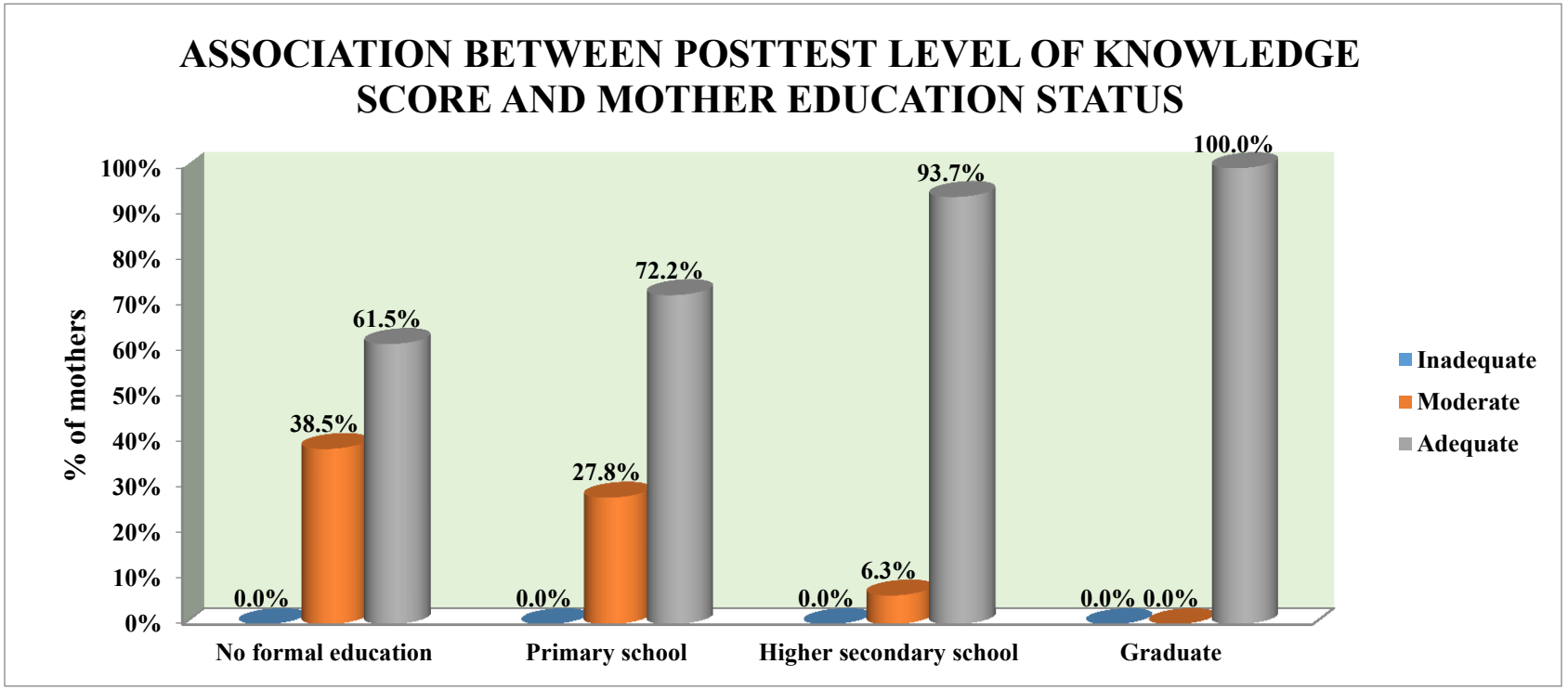
Knowledge score regarding vomiting was 45.00 % in pretest & 85.60 % in posttest, knowledge score regarding diarrhoea was 45.60 % in pretest & 82 .60 % in posttest, knowledge score regarding constipation was 51 .00 % in pretest & 83.00 % in posttest, knowledge score regarding napkin rashes was 42 .00 % in pretest & 81.40 % in posttest, knowledge score in physiological jaundice was 32 .00 % in pretest & 79 .40 % in posttest

Fig 4.14 Percentage distribution of domain wise knowledge gain score on Minor disorders of newborn



Postnatal mother's gained knowledge regarding vomiting is 40.60%, postnatal mother's gained knowledge regarding diarrhoea is 37.00%, postnatal mother's gained knowledge for constipation is 32.00%, postnatal mother's gained knowledge regarding napkin rashes is 39.40%, postnatal mother's gained knowledge in physiological jaundice is 47.40%

Fig4.16 Percentage distribution of association between post test level of knowledge score and mother education status



In no formal education mothers gained knowledge about Nil inadequate 38.5% in moderate, & 61.5% comparision of pre & post test

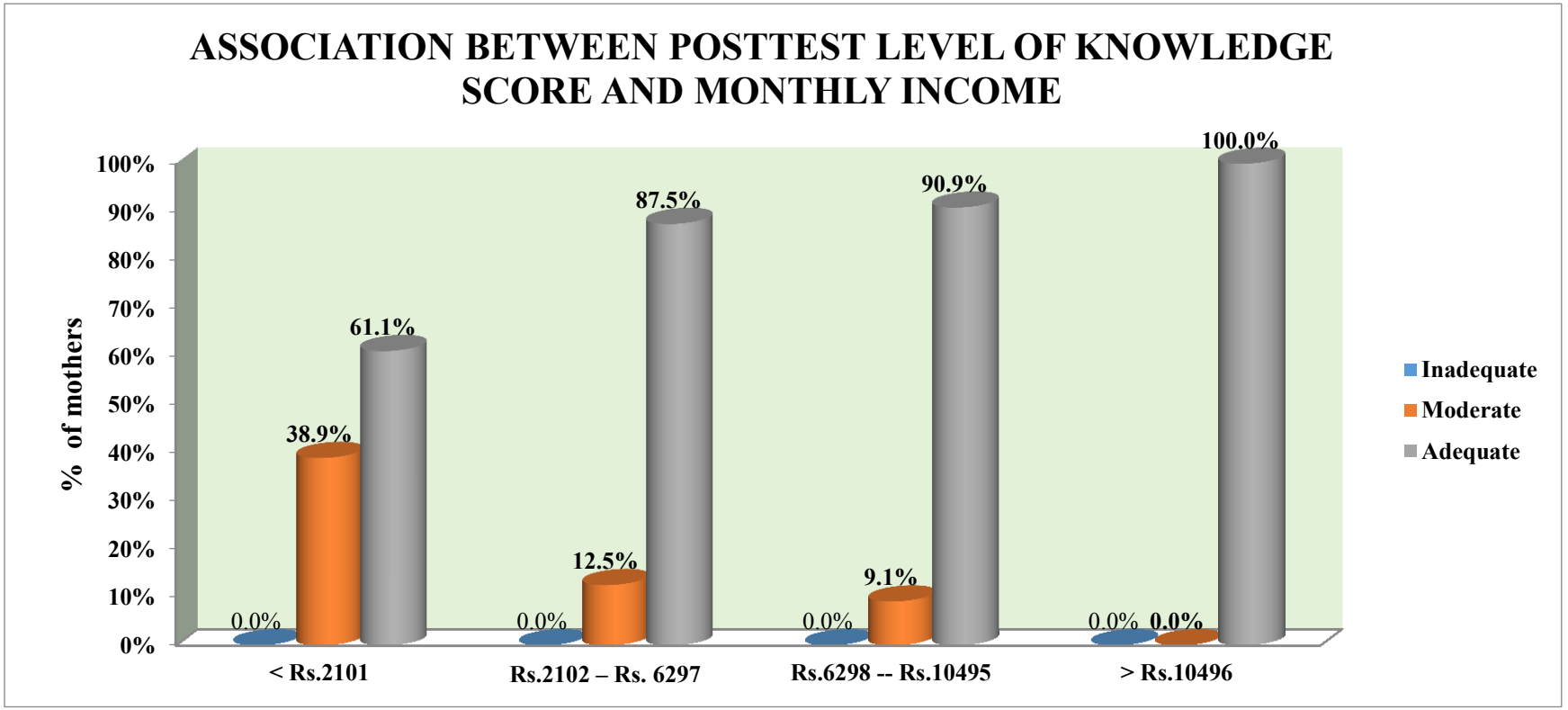
In primary school education mothers gained knowledge about Nil in inadequate , 27.8 % in moderate, & 72.2 % comparision of pre & post test

In higher sec. school education mothers gained knowledge about Nil inadequate, 6.3% in moderate, & 93.7% comparision of pre & post test

In no formal education mothers gained knowledge about Nil in inadequate, Nil in moderate, & 100 % comparision of pre & post test

.

Fig4.17 Percentage distribution of association between post test level of knowledge score and monthly family income



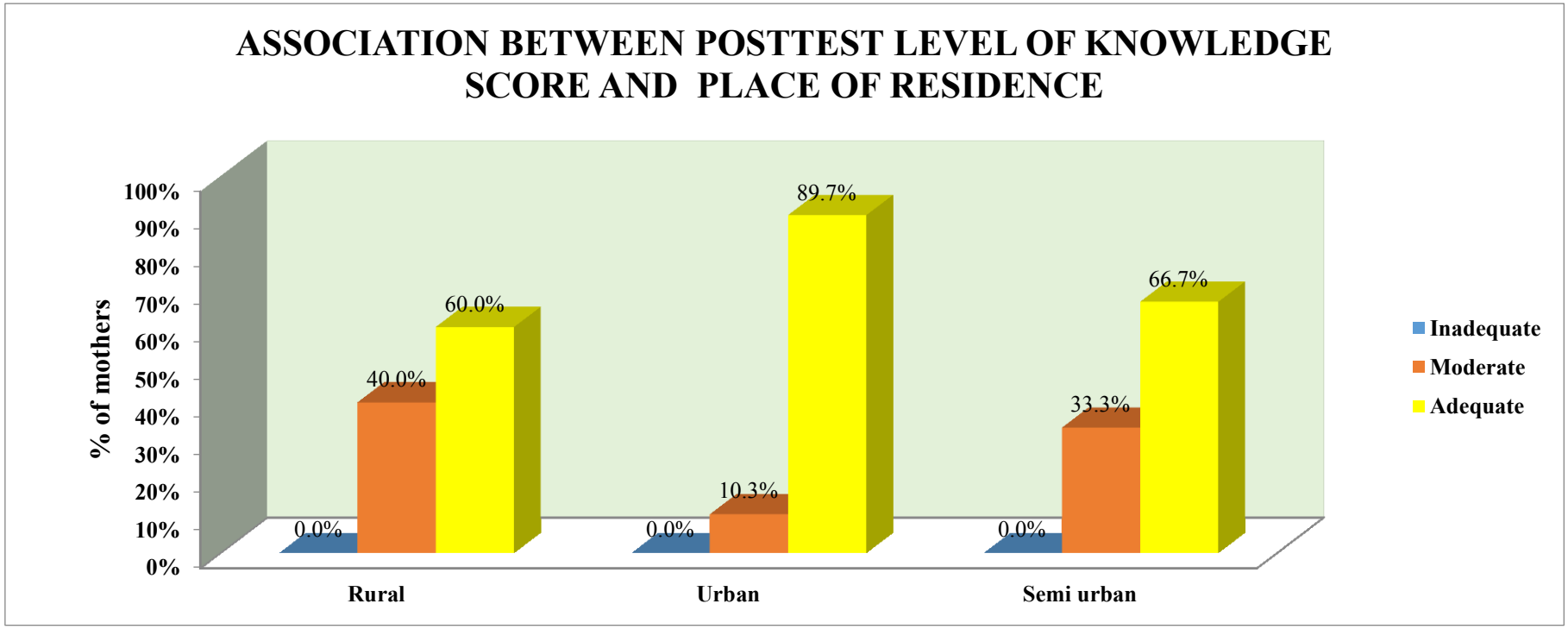
Income of <Rs.2101mothers gained knowledge as nil inadequate, 38.9% moderate , & 61.1% comparision of pre & post test

Income of Rs.(2102-6297)mothers gained knowledge as nil inadequate, 12.5% moderate ,& 87.5% comparision of pre & post test

Income of Rs.(6298- 10495)mothers gained knowledge as nil inadequate, 9.1% moderate, & 90.9% comparision of pre & post test

Income of >Rs 10496 mothers gained knowledge as nil inadequate, nil moderate, & 100.0% comparision of pre & post test

Fig4.18 Percentage distribution of association between post test level of knowledge score and place of residence

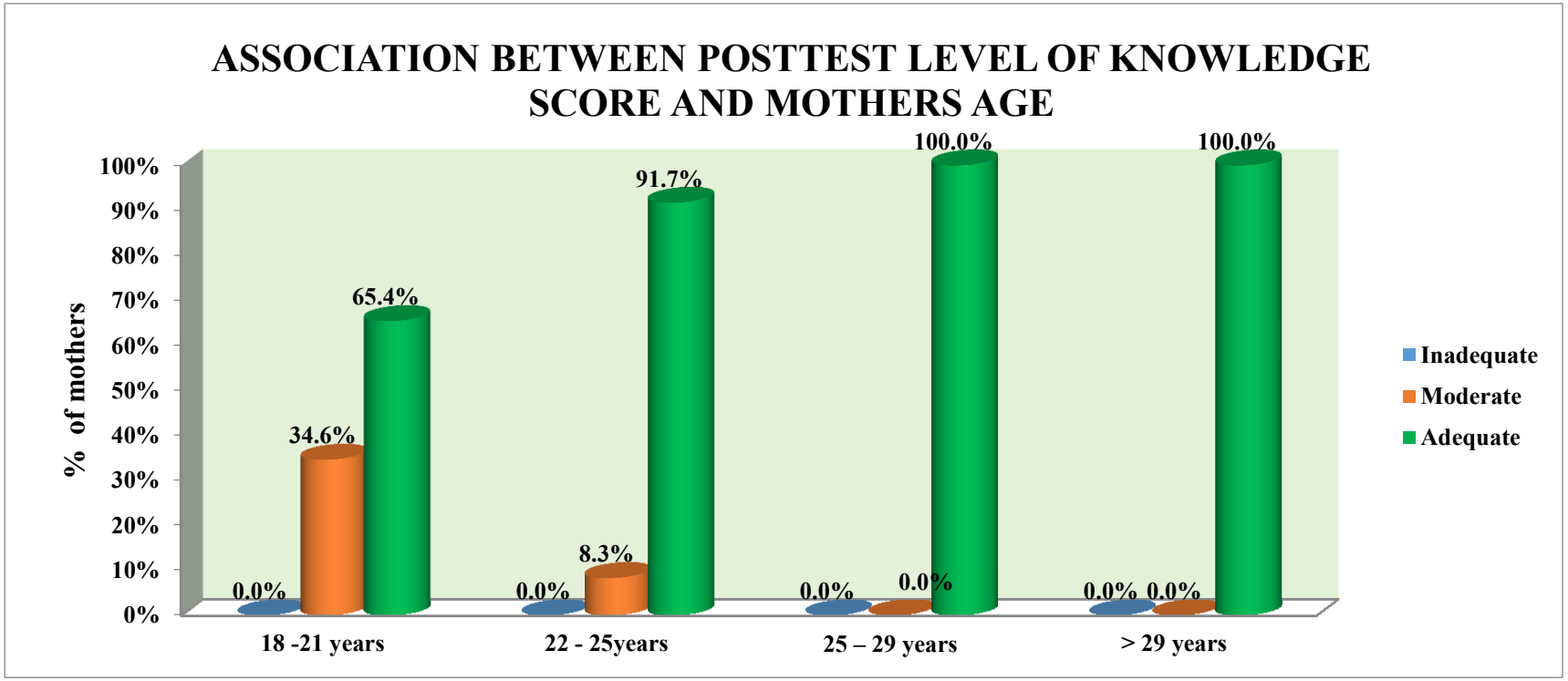


Mothers were rural areas gained knowledge of nil inadequate, 40.0% moderate, & 60.0% comparision of pre & post test

Mothers were urban areas gained knowledge of nil inadequate, 10.3% moderate, & 89.7% comparision of pre & post test

Mothers were semi urban gained knowledge of nil inadequate, 33.3% moderate ,& 66.7% comparision of pre & post test

Fig4.19 Percentage distribution of association between post test level of knowledge score and mother age



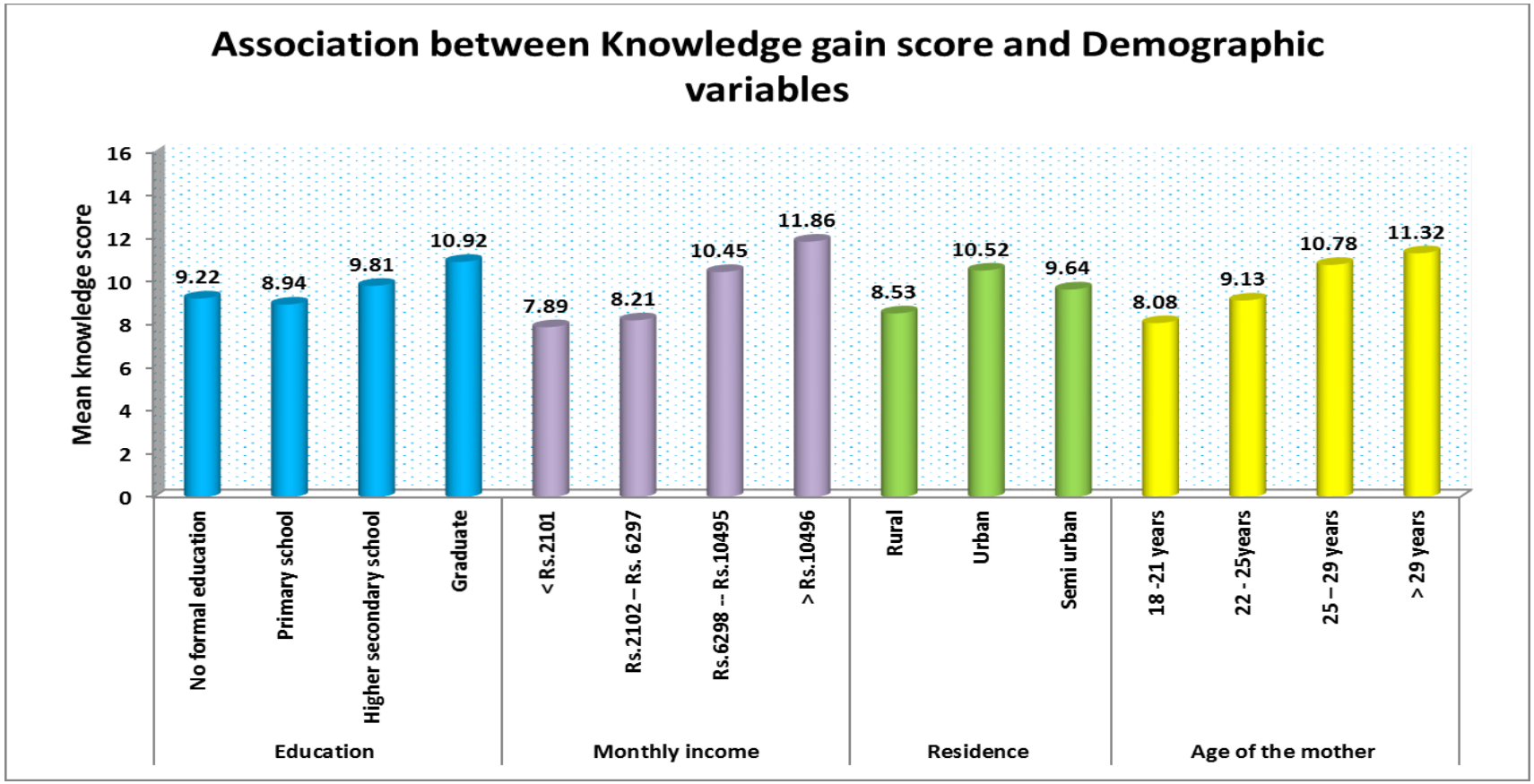
Mothers age of (18 – 21 years) gained knowledge nil inadequate, 34.6% moderate, & 65.4% comparision of pre & post test

Mothers age of (22 – 25 years) gained knowledge nil inadequate, 8.3% moderate, & 91.7% comparision of pre & post test

Mothers age of (25 – 29 years) gained knowledge nil inadequate, nil moderate, & 100.0% comparision of pre & post test

Mothers age of >29 years gained knowledge nil inadequate, nil moderate, & 100.0% comparision of pre & post test

Fig4.20 Percentage distribution of association between knowledge gain swcore and demographic variables



INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE, CHENNAI 600 003

EC Reg.No.ECR/270/Inst./TN/2013
Telephone No.044 25305301
Fax: 011 25363970

CERTIFICATE OF APPROVAL

To

P.Seshamalini
M.Sc. (N) I Year Student
College of Nursing
Madras Medical College
Chennai 600 003

Dear P.Seshamalini,

The Institutional Ethics Committee has considered your request and approved your study titled **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TEACHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEW BORN AMONG POST NATAL MOTHERS ADMITTED IN POST NATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN AT CHENNAI"-NO.39072017**

The following members of Ethics Committee were present in the meeting hold on **11.07.2017** conducted at Madras Medical College, Chennai 3

1. Prof.Dr.C.Rajendran, MD., :Chairperson
2. Prof.R.Narayana Babu,MD.,DCH.,Dean,MMC,Ch-3 : Deputy Chairperson
3. Prof.Sudha Seshayyan,MD., Vice Principal,MMC,Ch-3 :Member Secretary
4. Prof.S.Mayilvahanan,MD,Director,Inst. of Int.Med,MMC, Ch-3 : Member
5. Prof.A.Pandiya Raj,Director, Inst. of Gen.Surgery,MMC : Member
6. Prof.Rema Chandramohan,Prof.of Paediatrics,ICH,Chennai : Member
7. Prof. Susila, Director, Inst. of Pharmacology,MMC,Ch-3 : Member
8. Thiru S.Govindasamy, BA.,BL,High Court,Chennai : Lawyer
9. Tmt.Arnold Saulina, MA.,MSW., :Social Scientist
10. Tmt.J.Rajalakshmi, JAO,MMC, Ch-3 : Lay Person

We approve the proposal to be conducted in its presented form.

The Institutional Ethics Committee expects to be informed about the progress of the study and SAE occurring in the course of the study, any changes in the protocol and patients information/informed consent and asks to be provided a copy of the final report.

Member Secretary – Ethics Committee

MEMBER SECRETARY
INSTITUTIONAL ETHICS COMMITTEE
MADRAS MEDICAL COLLEGE
CHENNAI-600 003

REQUISITION LETTER

From

P. Seshamalini

M.sc (N) –II year student,

College of Nursing,

Madras Medical College, Chennai-3.

To

DIRECTOR AND SUPERINTENDENT

Institute of Obstetrics and Gynaecology and

Government Hospital for Women and Children

Egmore, Chennai- 08.

Through,

PRINCIPAL,

College of Nursing, Madras Medical College,

Chennai – 03.

Respected Sir/Madam,

Sub: Requesting permission to conduct research for Dissertation as per requirement at Institute of Obstetrics and Gynaecology and Government Hospital for Women and Children Egmore, Chennai-08.

Forwarded
6.12.17
for PRINCIPAL
COLLEGE OF NURSING
MADRAS MEDICAL COLLEGE
CHENNAI - 600 003.

I M.Sc Nursing II- year student has to conduct the research study for the fulfillment of MSc(N) programme. My topic is "**A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TECHING PROGRAMME ONKNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI-08.**" The data collection period is from 02.01.2018 to 27.01.2018 between 8am - 4pm in postnatal ward at Institute of Obstetric and Gynaecology and Government Hospital for Women and Children Egmore, Chennai-08.

I request you to permit me to conduct the above study and I assure that I will not disturb the routine activities of the postnatal ward.

Thanking You

Signature of H.O.D

V. Vijaya 6.12.17

Yours faithfully,

P. Seshamalini

(P.SESHAMALINI)

Permitted

Encl: Copy of Institutional Ethics Committee Approval Letter.

22/12/17

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Ms. P.Seshamalini (M.Sc Nursing) II year student College of Nursing, Madras Medical College which is to be used in her study titled, **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TECHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI-08"** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide .Then she can proceed to do the research.

29/12/17

PROF. Dr. ROSALINE RACHEL, M.Sc., (N), Ph.D.,(N)
PRINCIPAL
MMM COLLEGE OF NURSING
No.131, SAKTHI NAGAR,
NOLAMBUR, CHENNAI - 600 095.

ROSALINE RACHEL Signature with seal

Name : Dr. Roselin Rachal, M.Sc(N), Ph.D.

Designation : Principal

College : College of Nursing,
Madras Medical Mission,
Anna Nagar, Chennai.

Place : Chennai.

Date :

CERTIFICATE OF CONTENT VALIDITY

This is to certify that the tool constructed by Ms. P.Seshamalini (M.Sc Nursing) II year student College of Nursing, Madras Medical College which is to be used in her study titled, **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TECHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI-08"** has been validated by the undersigned. The suggestions and modifications given by me will be incorporated by the investigator in concern with their respective guide .Then she can proceed to do the research.

Signature with seal

Name : S. RAJESWARI

Designation : READER

College : College of Nursing,
Sri Ramachandra Medical University,
Porur, Chennai.

Dr. S. RAJESWARI
Associate Professor,
Faculty of Nursing
Sri Ramachandra University
Porur, Chennai-600 116.

Place : Chennai.

Date : 29/12/2017

CERTIFICATE OF TAMIL EDITING

This is to certify that the dissertation work topic **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TECHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI-08"** done by Ms. P.Seshamalini (M.Sc Nursing) II year student, College of Nursing, Madras Medical College is edited for Tamil language appropriateness.

NAME : தி.ப. சம்பத், M.A., B.Ed.,

DESIGNATION : B.T. (ASSIST) - TAMIL

PLACE : அரசு உயர் நிலைப்பள்ளி - கேசவராஜகுப்பம்

DATE : 22.06.18

SIGNATURE WITH SEAL : 22/6/18

தி.ப. சம்பத், எம்.ஏ., பி.எட்.,
தமிழாசிரியர்
அரசு உயர்நிலைப் பள்ளி,
கேசவராஜகுப்பம் - 631 208,
திருவள்ளூர் மாவட்டம்.

CERTIFICATE OF ENGLISH EDITING

This is to certify that the dissertation work topic **"A STUDY TO ASSESS THE EFFECTIVENESS OF PLANNED TEACHING PROGRAMME ON KNOWLEDGE OF MINOR DISORDERS OF NEWBORN AMONG POSTNATAL MOTHERS ADMITTED IN POSTNATAL WARD AT INSTITUTE OF OBSTETRICS AND GYNAECOLOGY AND GOVERNMENT HOSPITAL FOR WOMEN AND CHILDREN, CHENNAI-08"** done by Ms. P.Seshamalini (M.Sc Nursing) II year student, College of Nursing, Madras Medical College is edited for English language appropriateness.

NAME : C. VIJAYAN B.A., B.Ed.,

DESIGNATION : B.T ASST. ENGLISH

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DATE : 22.06.18

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